Department of Health and Human Services

Tribal Consultation Report 2005

Prepared by:

The Office of Intergovernmental Affairs

Jack Kalavritinos, Director

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MESSAGE FROM THE DIRECTOR

This report reflects the many activities undertaken by HHS and Tribes throughout fiscal year 2005. The progress we have made is a tribute to the strength of our partnership and reflects a major collective accomplishment. Consultation serves as the foundation of this partnership and Secretary Leavitt remains committed to working with Tribes on a government-to-government basis. In March, he wrote the following in reference to the revised HHS Tribal Consultation Policy:

> *"The Policy reflects the collective efforts undertaken and our desire to build upon the partnerships formed. I believe it also reiterates the commitment to the government-to-government relationship that exists between the United States and Federally recognized Indian Tribes."*

Principal among our successes in 2005 was the revision of the HHS Tribal Consultation Policy. This policy was transmitted by Secretary Leavitt to Tribes on March 11 and signed by former Secretary Thompson on January 14, 2005. These actions were the culmination of many months of work by a Tribal/Federal team. Special thanks to my predecessor, Regina Schofield, for her efforts to help initiate and make this process a reality. We greatly appreciate the dedication of the national and regional Tribal organizations that enthusiastically lent their expertise to support this project. Elected Tribal Officials representing all IHS Areas as well as representatives of major Tribal organizations met in several face-to-face meetings and numerous conference calls to complete the policy. In addition to the Workgroup, Tribes and Tribal organizations submitted over 300 written comments to the draft policy. The Consultation Policy which culminated from this effort is a testimony to the results of effective consultation between HHS and sovereign Tribal nations.

Another success we celebrate is the strong support the President showed to Indian Country in his HHS budget proposal for 2007. Because of the effectiveness of the consultation process in 2005, the President's budget requests sustained or enhanced funding for HHS programs that serve Tribes.

Many individuals work behind the scenes to support Tribal Governments and Native American communities. Thanks to the Deputy Secretary Alex Azar, Deputy Chief of Staff Kerry Weems, Assistant Secretary Charles Johnson, IHS Director Dr. Charles Grim, and ANA Commissioner Quanah Crossland-Stamps, as well as the other senior officials who lead divisions to achieve progress on the health *and* human service activities in Indian Country. The HHS Tribal Liaisons, located in all Staff and Operating Divisions, are the people we turn to for every major activity undertaken by the Office of the Secretary. We encourage you to contact them for assistance. The liaisons contact list is included in this report.

Finally, I wish to express my gratitude to those individuals who developed this consultation report. Jeremy Marshall, a participant in the HHS Emerging Leader Program (ELP), and Sarah Potter, a Presidential Management Fellow (PMF), provided significant assistance in collecting and compiling the information in this report and developing the report template. Chen-Tin Tsai, another Emerging Leader, and Valerie Jordan, ICNAA Program Assistant, assisted with report graphics. Special thanks to Emerging Leader Rachel Banov who compiled, wrote, and edited this report. Lastly, I want to thank Dr. Eric Broderick and Gena Tyner-Dawson for their efforts to oversee this project. Dr. Broderick's service to the Office of Intergovernmental Affairs, including his yearly contribution to this report, has been invaluable. He is a dedicated public servant who has been a senior leader in the Indian Health Service and assigned to the Intergovernmental Affairs Office for four years. Best of luck to him in his new senior capacity at SAMHSA.

The year 2006 will be an exciting one. We will continue our focus on Tribal Consultation. In addition, Tribes have expressed interest in consulting on Medicare Modernization Act implementation, as well as pandemic planning and preparedness in Indian Country. Please feel free to review this report online at our office's website: http://www.hhs.gov/ofta.

Respectfully,

Jack Kalavritinos
Director, Intergovernmental Affairs
Office of the Secretary

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EXECUTIVE SUMMARY

This is the fifth annual consultation report developed by the U. S. Department of Health and Human Services (HHS) in compliance with the HHS Tribal consultation policy. It provides an overview of the array of Tribal consultation activities conducted by HHS programs during fiscal year 2005 and includes issues raised by the Tribes, as well as the progress made within HHS to address those issues.

In his Native American Heritage Month Proclamation on November 2, 2005, President Bush reaffirmed tribal sovereignty and the right of American Indian and Alaska Native Tribes to self-determination.

> *"Our young country is home to an ancient, noble, and enduring native culture and my Administration recognizes the defining principles of tribal sovereignty and the right to self-determination."*

One of the fundamental signs of the respect for Tribal sovereignty referred to by the President in the quote above is the action of consulting with Tribes before actions are taken that will affect them. HHS has an extensive history of promoting and conducting such consultation. This report chronicles the many Tribal consultation activities that have been conducted across HHS in 2005.

In 2005, Tribal consultation at HHS took many forms. A national budget consultation session that focused on the health and human services budget priorities of Tribes, regional consultation sessions coordinated by HHS regional directors, and HHS Division sponsored consultation all served to provide Tribes multiple opportunities for Tribes to make their views and priorities known to HHS officials on a wide variety of health and human services issues. HHS senior staff continued to travel throughout Indian Country. This travel has been at the invitation of Tribal leaders who have repeatedly stated that there is no substitute for seeing health and human service conditions first hand in Indian communities.

This report catalogs these and other forms of consultation undertaken over the past year.

Section 1: Tribal Priorities on page 5 discusses the various Tribal priorities shared through HHS, regional, and division consultation efforts, including: access to health services; behavioral health; data and research; eliminating health disparities; emergency preparedness/homeland security; funding and budget issues; health promotion and disease prevention; increased access to HHS resources; legislation; Medicaid; Medicare Modernization Act; and Tribal consultation and intergovernmental relations.

Section 2: Overview of Consultation Activities on page 39 lists the consultation efforts that have been undertaken by HHS Regional Offices and Divisions and others during the last year. In addition to the nine regional Tribal consultations and the HHS Annual Tribal Budget Consultation Session, many other regions and divisions consulted with Tribes on specific issues. In order to distinguish national from local or regional consultation efforts, this section is organized according to type of consultation, including: regional Tribal consultation sessions; HHS Annual Tribal Budget Consultation Session; HHS leadership visits to Indian Country; Intradepartmental Council on Native American Affairs (ICNAA); Red Lake response; Medicare Modernization Act; workgroups and task forces; Tribal delegation meetings; region- and division-specific consultation; and Tribal conferences and summits. Information about the date(s), sponsoring region or division, membership or attendees, and a brief summary are included for each consultation activity.

Section 3: Outcomes and Accomplishments on page 79 connects Sections 1 and 2. Outcomes on the Tribal priorities achieved through Tribal consultation are included in this section. Major HHS responses to Tribal priorities, as well as region and division outcomes and accomplishments, are provided in this section.

The major HHS outcomes and accomplishments for fiscal year 2005 include:

- Increased HHS Tribal Funding
- HHS Tribal Consultation Policy
- Regional Tribal Consultation Sessions/Budget Consultation Session
- Intradepartmental Council for Native American Affairs
- Federal-Tribal-State Human Services Intergovernmental Collaboration
- Medicare Part D Implementation
- HHS Response to Red Lake
- HHS Response to Hurricanes Katrina and Rita
- First Lady's Visit to Indian Country – Helping America's Youth.

Section 4: Tribal Assessments of Consultation Efforts on page 99 provides a summary of Tribal feedback on the Annual Tribal Budget Consultation Session and Regional Tribal Consultation Sessions.

Finally, the expanded **Appendices** section, which starts on page 103, offers a wealth of supportive information to maximize this report's use as a resource. The Office of Intergovernmental Affairs and Regional Office staff lists; ICNAA members and liaison roster; two tables reflecting HHS funding for tribes; Federal-State-Tribal Human Services Collaboration Final Report; revised HHS Tribal Consultation policy; HHS organizational chart, Indian Health Service Areas map; acronym descriptions; and a comprehensive index are all parts of the Appendices section.

Of particular interest is Appendix E – the Federal-State-Tribal Human Services Collaboration Final Report – on page 113, which documents the partnership between HHS, the National Congress of American Indians and the American Public Human Services Association. This partnership has increased the human services collaboration between states and Tribes and was a direct result of requests from Tribal leaders that HHS assist in facilitating these partnerships.

Section 1

Tribal Priorities

SECTION 1: TRIBAL PRIORITIES

CONSULTATION SESSIONS TRIBAL PRIORITIES

During the course of the Regional Consultation Sessions and the HHS Annual Tribal Consultation Session, Tribes raised a number of specific budget, policy, legislative, and regulatory and concerns. The list below aggregates these issues into broad categories. This list remains very similar to the list included in the 2004 HHS Tribal Consultation Report.

Access to Health Services
Behavioral Health
Data and Research
Eliminating Health Disparities
Emergency Preparedness/Homeland Security
Funding and Budget Issues
Health Promotion and Disease Prevention
Increased access to HHS resources
Legislation
Medicaid
Medicare Modernization Act
Tribal Consultation and Intergovernmental Relations

In addition to these broad, over-arching categories, Tribes mentioned a number of very specific concerns at many sessions. The list below includes a sample of issues that were raised frequently by the Tribes.

1. Increased funding
2. Indian Health Care Improvement Act reauthorization
3. TANF reauthorization and the need for more outreach on Tribal TANF
4. Increased awareness of Tribal needs and funding for emergency preparedness/homeland security
5. Increased flexibility by HHS when dealing with Tribes
6. Increased access to HHS programs for Tribes through elimination of barriers
7. Support passage of legislation authorizing self-governance outside IHS
8. Support Tribal consultation
9. Develop Tribal research capacity and strategy
10. Medicare and Medicaid issues
11. Tribal Head Start
12. Positive youth development and suicide prevention
13. Services for Indian Veterans
14. Aging issues, i.e., long-term care, improve services for the elderly
15. Methamphetamine use in Indian Country
16. Diabetes prevention and treatment
17. High cost of pharmaceuticals
18. Medicare Modernization Act implementation
19. Establish direct funding of HHS programs currently funded by state block grants to Tribes
20. State accountability for HHS funding received for services for Tribes
21. Increase resources for facility construction and sanitation facilities

DIVISION TRIBAL PRIORITIES

This section of the report describes the objectives developed by various HHS programs to address the Tribal priorities identified in 2004.

Administration for Children and Families (ACF), Child Care Bureau (CCB)

Objective 1: Increase opportunities for research on Tribal child care issues.

Background: The 2003 ACF Tribal Consultation presenter stated that *"The Child Care Bureau has been appropriated 10 million dollars for research and evaluation since 2000. Little information is known or available which is pertinent to the Tribal child care community. Specific research funds must be set aside to gather data, and research the effectiveness of early childhood practices in the Tribal community if we are to improve the quality of care for Indian children."*

While priorities vary from year to year, CCB typically issues an announcement seeking research and scholarship applications for research purposes. Tribes and American Indian students may apply for funding under CCB's research announcement. Eligible applicants for research typically include non-profit agencies and organizations, public and private institutions such as colleges and universities (including Tribal colleges and universities), and agencies of State and local government (including Tribal government agencies). American Indian graduate students may participate in a scholarship research application as long as a university or college applies on the student's behalf; the student is pursing a doctorate degree; and the student anticipates completing a child care-related dissertation.

In 2004, at the request of several Oklahoma Tribes, CCB agreed to support the efforts of a research project on care provided by family, friends and neighbor providers (i.e., informal child care) because this project has the potential to be replicated by other Tribal child care programs across the country.

Activity 1: CCB is funding the Oklahoma Child Care Resource and Referral Association, Inc. (OCCRRA) to participate in Phase II of the Families and Work Institute's "Sparking Connections" project, a national research and demonstration initiative focusing on family, friend and neighbor care. Specifically, this two-year project will: 1) demonstrate and evaluate services provided by Tribes to family members who care for children or whose children receive a Child Care and Development Fund (CCDF) subsidy for child care; 2) demonstrate successful collaboration between child care resource and referral, Tribes and retailers to meet the needs of families in their communities; and 3) engage employers in activities to improve the quality of child care received by children of their employees and other children in the communities. This project is unique because it serves as a model State-wide initiative demonstrating collaboration between OCCRRA and several Oklahoma Tribes. The Cherokee Nation has taken a lead role in coordinating this project with OCCRRA and the other participating Tribes. CCB is working closely with OCCRRA and the Cherokee Nation to develop an evaluation plan, which will include replication opportunities for other Tribes.

Activity 2: CCB is funding a three-year market rate survey research study with Oregon State University to examine how well market rate surveys assess the price of care in various communities, what methods validate market rate survey findings, and the effects of child care subsidies on the child care market. States, Territories and Tribes will be surveyed to assess current market-rate survey practices and issues.

Activity 3: CCB is funding a two-year research study titled, "The Role of Tribal Child Care Programs in Serving Children Birth to Five," to investigate American Indian child care directors' perceptions of the Reservation community's efforts to promote and to preserve cultural integrity in the local transmission of cultural values to children aged birth to five who are enrolled in Tribal child care programs on American Indian reservations. In addition, the study will address the directors' perceptions of how State-wide quality improvement systems are (or are not) assisting them in their efforts to promote continuity of cultural education and quality child care. Sixteen directors from child care centers in Tribal communities will participate in a multiple case-study design. The program directors, each a member of a different Tribe, will represent sites located in diverse geographic regions and will be selected to provide variation among different stages in their professional careers and encountering different types of challenge in their work.

Expected Outcome(s): Overall, these projects will begin to fill a void in Tribal child care research. Evaluation tools have been built into the project design for these projects. Specifically, these projects will accomplish the following: 1) Through parent education and support, partnerships, and other supportive activities, the quality of child care provided by informal providers will be enhanced. 2) The market-rate survey study will inform policy and program choices about the impact of child care subsidies on child care prices, about the ways child care assistance impacts other families needing child care, and about strategies for forecasting program expenditures. 3) An assessment will be made about how Tribes are promoting and preserving cultural integrity in the transmission of values in Tribal child care programs and how State-wide quality-improvement systems are assisting Tribal child care programs in their efforts to promote continuity of cultural education and values and quality child care.

Divisions and Other Groups Involved in Addressing Priority: Cherokee Nation (coordinating on behalf of Choctaw Nation, Eastern Shawnee Tribe, and United Keetoowah Band); Child Care Bureau; Oklahoma Child Care Resource and Referral Association; Oregon State University; University of Nebraska; Tribal Child Care Directors

Objective 2: Build or enhance school-readiness capacity in Tribal communities.

Background: The 2003 ACF Tribal Consultation presenter stated, *"Since most of our children attend public school, a greater effort must be placed on ensuring that Tribes are included as States move forward with their early learning initiatives."* The 2004 ACF Tribal Consultation presenter stated, *"Tribes need more concentrated technical assistance in GSGS planning and inclusion in early learning initiatives."*

Both States and Tribes are required by Federal statute and CCDF regulations to describe within their CCDF two-year plans how they are coordinating with each other to provide child care services within their boundaries. Since 2002, the President's Good Start, Grow Smart (GSGS) Early Learning Initiative has been a catalyst for increased State-Tribal coordination and collaboration around the development and implementation of early learning guidelines, the establishment of State-wide professional development systems, and the coordination of various Federal and State early care and education programs and funding streams. CCB has provided technical assistance to Tribes on early learning and literacy efforts related to the President's GSGS initiative at the National Tribal Child Care Conference, ACF Regional Tribal Conferences, and Tribal Cluster Trainings.

Activity 1: CCB disseminated a booklet that reinforces GSGS coordination goal. This booklet—*Tribes and States Working Together—A Guide to Tribal-State Child Care Coordination*—is the third in a series of Tribal technical assistance guides distributed by the Child Care Bureau since 2004. The CCB developed this Tribal Guide for the 11th National American Indian and Alaska Native Child Care Conference in April 2005. Throughout *Tribes and States Working Together—A Guide to Tribal-State Child Care Coordination*, State and Tribal Child Care Administrators highlight the benefits of working together toward a common goal.

In July, CCB's Associate Commissioner sent a letter to State and Tribal CCDF Administrators encouraging them to begin or enhance a dialogue in their States about the ways Tribal and State CCDF programs can become true partners in providing child care services to children and families. The Associate Commissioner's letter highlighted the Tribal Guide and also referenced other technical assistance resources available to assist in Tribal-State child care coordination efforts.

Activity 2: Through its Tribal Child Care Technical Assistance Center (TriTAC), CCB is working with the National Center for Rural Early Childhood Learning Initiatives at Mississippi State University on a Tribal curriculum toolkit. The purpose of the toolkit is to provide a resource to Tribal early childhood coordinators/program directors that will assist them in providing training for staff on teaching and supporting the use of Tribal languages in a developmentally appropriate manner. The National Center for Rural Early Childhood Learning Initiatives proposes to develop a prototype of a toolkit and an accompanying training manual in collaboration with TriTAC and with recognized authorities in American Indian education. Tribal child care grantees will be offered training on the toolkit at several CCB-sponsored Tribal Cluster Trainings in 2006.

Expected Outcome(s): As Tribes work with States on the development or enhancement of State early learning guidelines, Tribes can influence State policy by bringing important cultural and Native language considerations to the attention of State policy-makers. By accessing State training activities, Tribal child care programs will have the opportunity to build their capacity to provide quality care, while at the same time increase their ability to serve more families because the funds previously spent on professional development activities can be diverted to direct services. Through the toolkit, Tribal child care programs will increase the capacity-building of early childhood programs to teach language and culture, and children in child care settings will have the opportunity to build or enhance their acquisition of Native language and culture.

Divisions and Other Groups Involved in Addressing Priority: Child Care Bureau; National Center for Rural Early Childhood Learning Initiatives; Tribal Child Care Technical Assistance Center

Agency for Healthcare Research and Quality (AHRQ)

<u>Priority 1: Funding and Related Issues</u>

Objective: To make more funds and other types of assistance available to Tribes and Tribal organizations.

Background: This objective is consistent with the Department's emphasis on supporting Tribes and Tribal organizations. During the FY06 National Budget Consultation, the Tribes primarily asked AHRQ for assistance in developing data that they believe will help them in their efforts to get more resources from Congress. More specifically, they asked for assistance in developing estimates of the long-term savings produced by current expenditures on prevention activities as well as early interventions to prevent and treat the complications of diabetes through the Special Diabetes Initiative. Tribes also asked for direct, non-competitive funding of the Tribal epidemiology centers (epi centers).

Activity 1: AHRQ will continue its efforts to become better known throughout Indian country to generate more applications for funding from AI/AN researchers/Tribes/Tribal organizations. For example, AHRQ's coordinator of AI/AN activities has spoken and will continue to speak before groups of AI/AN researchers to generate knowledge of, and interest, in the Agency's work.

Activity 2: AHRQ is prepared to help Tribes explore how best to develop the requested data (see above) and has let the IHS and the National Indian Health Board know of its willingness to lend assistance. AHRQ cannot provide direct, non-competitive funding to the epi centers—it has neither the resources nor authority to do so. However, AHRQ staff did discuss how the Agency might lend assistance to the epi centers with the director of that program.

Expected Outcome(s): AHRQ became a partner in the Native American Research Centers for Health (NARCH) program in FY05, a unique health research program co-led by NIH and IHS which makes research awards directly to Tribes to run research of importance to them. Through this program, AHRQ is supporting specified research efforts of a Tribal organization. AHRQ competitively awarded a new grant to a Tribal organization in FY05 and continued funding of two others. We hope that in the future, Tribes and Tribal organizations will submit more applications to AHRQ for support of research activities.

Divisions and Other Groups Involved in Addressing Priority: All other HHS divisions; National Indian Health Board; American Indian Higher Education Consortium

<u>Priority 2: Increased Access to HHS Programs</u>

Objective: To increase access to AHRQ funding opportunities.

Background: This is in keeping with departmental objectives.

Activity 1: See Activity #1 above.

Activity 2: Led a department-wide effort to develop an advisory group of tribal leaders to provide the Department with input on their tribes' research needs and priorities. Part of the purpose of the effort is to create synergy among the different departmental components and, in so doing, increase access to research funding Department-wide.

Expected Outcome(s): In FY05, a multi-Tribal organization in Alaska was awarded a grant from AHRQ. Also, increased information on tribal research needs and priorities provided by tribal leaders and cross-division communication on these needs and priorities will hopefully lead to greater synergy among the organizational components of the Department and, as a result, the support of more high priority research than could be undertaken by each Departmental component individually.

Divisions and Other Groups Involved in Addressing Priority: All departmental components are involved in increasing access to HHS programs.

<u>Priority 3: Data and Research</u>

Objective: To improve the collection and analysis of data/information on Tribal research and data needs.

Background: AHRQ's work in this area is consistent with departmental objectives.

Activity 1: AHRQ, working closely with ASPE, took the lead over the past two years in developing a group of Tribal leaders to inform the Department on Tribes' health research needs and priorities.

Activity 2: To improve the quality of the data available for the National Healthcare Quality Report (NHQR) and National Healthcare Disparities Report (NHDR), AHRQ entered into an annual Interagency Agreement with IHS that supports the generation of estimates of health care quality and access received by AI/AN from IHS facilities in IHS service areas. In addition, the Agency recently began an activity to combine information about hospitalizations of AIs/ANs in community hospitals from the Health Care Utilization Project (HCUP) with information about hospitalizations of AIs/ANs in IHS and Tribal facilities from IHS' National Patient Information and Reporting System to yield better national estimates of AI/AN hospital care.

Expected Outcome(s): Better understanding of the health research needs and priorities of Tribes; improved synergy among departmental organizations in responding to those needs and priorities; improved reporting of pertinent research activities and results to Tribes; improved data on AI/AN health care utilization, the quality of health care they receive and information on their access to health care services.

Divisions and Other Groups Involved in Addressing Priority: Other components of the Department participating in the effort to form a Tribal leaders group to provide input on Tribal research needs and priorities include IHS, ASPE, NIH, CDC, OMH, and IGA. IHS is working with AHRQ in developing better data for the NHQR and NHDR reports.

Assistant Secretary for Planning and Evaluation (ASPE)

Priority 1: Increased Access to HHS Programs

Objective: To increase understanding of programmatic and administrative barriers preventing American Indian, Alaska Native, and Native American (AI/AN/NA) communities from more fully accessing those HHS grants programs for which they are eligible as well as strategies for improving access.

Background: Increased access to HHS programs by AI/AN/NAs is a priority of the ICNAA and the Tribes as identified during FY05 regional Tribal consultation sessions. An ICNAA project using FY04 Tracking Accountability in Government Grants System (TAGGS) data indicated that for most of the HHS programs available to AI/AN/NA groups, very few are funding more than one or two Tribal groups and many are not reaching such organizations at all.

Activities: ASPE's Office of Human Services Policy and its partners including ASBTF, ANA and ICNAA have supported the *Barriers Study* to gather information on HHS officials and AI/AN/NA representatives' perspectives of the programmatic and administrative barriers. The study is being conducted from September 2004 to December 2005. A Workgroup that includes Tribal representation provides feedback during all phases of the study. The immediate outcome is the gathering of information through a survey of 148 HHS personnel, six focus groups with HHS personnel, and discussions with 150 Tribal representatives attending five national conferences.

Expected Outcome(s): A report that will synthesize the findings on barriers and solutions, discuss the similarities and differences in perspectives between HHS officials and Tribal representatives, and address practical considerations in implementing the suggested strategies.

Divisions and Other Groups Involved in Addressing Priority: In addition to the funding partners (see above), a Workgroup consisting of representatives from ACF, AoA, NIH, CDC, HRSA, SAMHSA, IHS, National Congress of American Indians, and the Tribal Self-Governance Advisory Committee met to advise the project staff and the contractor.

Priority 2: Data and Research

Project 1

Objective: To enhance knowledge of existing health and human service Federal, state and other relevant data sources pertaining to AI/AN/NAs as well as coverage gaps and possible remedies for these gaps in these data sources.

Background: High-quality, up-to-date data pertaining to AI/AN/NAs are necessary to understand the health and well-being of this population; identify social, economic and health disparities; and make statistical inferences about change. The data currently available on AI/AN/NAs are severely limited. Sample sizes of national surveys sponsored by the Federal government often are too small for analyses within racial and ethnic groups. In many cases, analyses are only possible when data from several years are pooled and this often is not done. There is a need to build on other recent work in this area and produce a current catalogue of relevant data sources and assessment of data gaps and remedies.

Activities: ASPE's Office of Human Services Policy is supporting a study entitled *Data on the Health and Well-being of American Indians, Alaska Natives, and Native Americans* that will compile information on existing health and human services data sources pertaining to AI/AN/NAs, explore the quality and usefulness of these data, and identify ways to improve the usefulness, quality and/or coverage of the data. The study will be conducted from October 2005 to November 2006. A Workgroup consisting of Tribal representatives will provide feedback throughout the study. The immediate outcome is the initiation of a series of research tasks by the contractor that address the study's objectives.

Expected Outcome(s): A descriptive catalogue of existing data sources and an overview paper on data gaps and options for addressing them. Information for these products will be obtained by an assessment of existing data sources, discussions with government and non-government officials working on AI/AN/NA data issues, and a synthesis of this information to identify gaps and remedies.

Divisions/Other Groups Involved in Addressing Priority: In addition to ASPE staff and the contractor, members of the HHS Data Council and its Working Group on Race and Ethnicity and officials of relevant HHS and non-HHS agencies will participate in this study.

Project 2

Objective: To improve racial and ethnic data within the Department including data pertaining to AI/AN/NAs.

Background: The HHS Data Council was formed to provide a forum and advisory body to the Secretary on health and human services data policy and to coordinate data collection and analysis activities in HHS in these areas. The Council meets monthly and workgroups meet periodically. The Council has established a Working Group on Racial and Ethnic Data to coordinate data activities and provide advice, technical assistance and staff support to the Council.

Activities: ASPE co-chairs the *HHS Data Council* on a permanent basis along with the Head of an Operating Division on a rotating basis. In addition, ASPE is a member of the *Working Group on Racial and Ethnic Data* described above. Currently the workgroup has presented a draft approach to the Council consisting of six possible strategies for improving racial and ethnic data. The immediate outcome of the Workgroup activities is an HHS minority data website that is currently being developed.

Expected Outcome(s): The workgroup has suggested the following additional activities: a coordinated analytical initiative to prepare special issue briefs on specific racial and ethnic minority populations, sponsorship of workshops, expansion of data collection and analytical capabilities in race and ethnicity data based on the National Health Interview Survey (NHIS), methodological work in support of a dual frame capability on the NHIS, and targeted expansion of data collection capability in major HHS surveys. The workgroup will present plans for these activities to the full Data Council for their review.

Divisions and Other Groups Involved in Addressing Priority: The Working Group on Racial and Ethnic Data includes members from the HHS Operating and Staff Divisions and is co-chaired by the OMH and SAMHSA.

Project 3

Objective: To establish an AI/AN Health Research Group within HHS. See AHRQ, Priority 3 above.

Project 4

Objective: To provide advice and assistance to the Department regarding health data issues and serve as a forum for interaction with interested private sector groups on a variety of these issues.

Background: The National Committee on Vital and Health Statistics (NCVHS) serves as the statutory public advisory body to the Secretary of Health and Human Services in the area of health data and statistics and meets quarterly. The NCVHS is composed of 18 individuals from the private sector who are experts in a wide variety of fields. The Committee's Subcommittee on Populations meets periodically and focuses on population-based health issues, including those pertaining to racial and ethnic minorities.

Activities: ASPE staffs the NCVHS and co-leads the Subcommittee on Populations with the Office of Minority Health. During the last several years, the Subcommittee has held several public hearings focusing on health data pertaining to AI/AN/NAs, including data needs, measurement issues, and barriers to collecting this data. The immediate outcome of this activity is the analysis and synthesis of the information gathered during these hearings.

Expected Outcomes: In late 2005, the Subcommittee will release a report entitled: *Eliminating Health Disparities: Strengthening Data on Race, Ethnicity, and Primary Language in the U.S.*

Divisions and Other Groups Involved in Addressing Priority: The Subcommittee on Populations includes experts from the private sector and representatives from HHS Operating and Staff Divisions.

Project 5

Objective: To provide information to help understand the high rates of obesity among AI/ANs, the nature of preventive interventions and their efficacy, and directions for future research.

Background: Studies indicate that AI/ANs of all ages and both sexes have a high prevalence of obesity that has increased over the past few decades. Associations between obesity and adverse health outcomes are well documented. However, a knowledge gap exists with regard to the etiology of obesity in the AI/AN population and effective preventive interventions.

Activities: ASPE's Office of Human Services Policy is supporting an in-house study entitled *Obesity and American Indian/Alaska Native Populations* to provide information that will help to understand the issue of obesity in AI/AN populations. This study is being conducted from January 2005 to June 2006. The immediate outcome of this activity is the gathering of information through a review of the literature and discussions with key government personnel involved in obesity prevention programs.

Expected Outcome(s): The product of this study will be an overview paper.

Divisions and Other Groups Involved in Addressing Priority: ASPE's Office of Human Services Policy is coordinating with ASPE's Office of Health Policy on this effort. In addition, key staff from IHS, CDC, NIH, and USDA is providing information for this study.

Project 6

Objective: To evaluate the diffusion and use of best practices for cardiovascular disease prevention and treatment in Indian Country.

Background: In an effort to assess health outcomes and to provide Tribes with timely and accurate health data, the IHS established Tribal-based epidemiology programs that provide research, training, and advocacy to eliminate disparities in health. Cardiovascular disease (CVD) is a leading cause of death among AI/ANs.

Activities: ASPE's Office of Health Policy transferred funds to IHS to conduct *A Study on Best Practices in Indian Health Care.* This study will examine the process and means of dissemination of local best practices used in relation to clinical care for and prevention of CVD within Federally and Tribally-operated programs. The Northern Plains Tribal Epidemiology Center and the Alaska Native Epidemiology Center are conducting separate studies on CVD that will be completed in December 2005 and December 2006 respectively. The immediate outcome of the Northern Plains Center study is a data assessment component that provides information on the identification of persons with CVD risk factors, their treatment regimes, and their compliance. The immediate outcome of the Alaska Native Center is a revised scope of work to be completed by December 2005.

Expected Outcome(s): The Northern Plains Tribal Epidemiology Center will produce a report that documents the establishment of a surveillance system for cardiovascular disease, and this report will be disseminated to 17 Tribes in the Northern Plains and their health systems. These outcomes are being measured through the use of the IHS Resource and Patient Management System (RPMS). The Alaska Native Center study will also focus on CVD but the expected outcome has not yet been specified.

Divisions and Other Groups Involved in Addressing Priority: Along with IHS and the two Tribal Epidemiology Centers noted above, health providers and patients from the Lower Brule Tribe in South Dakota are participants in the study conducted by the Northern Plains Tribal Epidemiology Center.

Priority 3: Health Promotion and Disease Prevention

Project 1

Objective: To exchange information between the U.S. and Mexico about the causes, prevention and treatment of type 2 diabetes among indigenous populations.

Background: In early 2005, Canada, U.S. and Mexico established the Security and Prosperity Partnership of North America. An objective of this partnership is to improve the health of indigenous people through targeted bilateral activities including health promotion, health education, disease prevention, and research.

Activities: ASPE along with staff from the National Institute of Salud Pu'blica (INSP) and Academy Health in DC are key players in planning for the *US/Mexico Indigenous People's Roundtable*. A preliminary consultation discussion has been held with the HHS Tribal Leaders Diabetes Committee. The immediate outcome of the planning meetings has been the identification of key planning contacts, possible Roundtable participants and a structure for the Roundtable meeting.

Expected Outcome(s): The Roundtable is planned for early 2006. The products of the Roundtable will include issue papers compiled by both the US and Mexican delegations. Outcomes will be measured by feedback from the participants in the Roundtable. If successful, this model could be expanded to include follow-up meetings with Mexico and similar discussions with Canada.

Divisions and Other Groups Involved in Addressing Priority: In addition to ASPE and INSP, FUNSALUD, a Mexican NGO that will help fund the meeting, is involved. Federal, private sector and Tribal representatives from both Mexico and the U.S. will attend the Roundtable.

Agency for Toxic Substances and Disease Registry (ATSDR)

Priority 1: Address environmental degradation and health issues impacting Tribes and their natural resources

Objective: Build the infrastructure of Tribes to address adequately the environmental health threats and problems impacting their community. Overall, ATSDR works on sites where Tribal Governments and organizations are consulted when a public health assessment or a public health consultation is developed.

Background: ATSDR remains committed to the concept of building capacity in environmental health within Tribal communities. The primary recommendations for CDC and ATSDR are related to: 1) receiving technical assistance on our Tribal Environmental Health Education Project; 2) infrastructure development for emergency preparedness, participation in preparatory activities, and direct access to emergency preparedness funds; 3) a report on CDC and ATSDR implementation of their new Tribal consultation policy; and 4) greater participation of Indian students from TCUs in CDC/ATSDR internships and other training programs.

Activity 1: ATSDR hosts a bi-annual Tribal Ad-Hoc Workgroup meeting where all Tribes are invited to participate. Even though ATSDR can only support ten participants, we open up the meeting to all Tribes in the country. ATSDR does understand that this is not official consultation on a government-to-government basis but uses this group to provide advice on our programs and policies and how to best consult with Tribes. At our July 13 meeting we discussed the components of ATSDR Tribal Consultation Policy. ATSDR received input from the Tribes on two primary issues: 1) components of the ATSDR Tribal Consultation Policy; and 2) merging the ATSDR policy with the Centers for Disease Control and Prevention's policy into one that will serve the needs of both agencies.

Activity 2: To address the disparities that exist between Tribes and states, ATSDR and EPA partnered to begin the assessment of American Indian Tribal emergency response capabilities. A pilot project was developed (FY03) working with nine Tribes nationwide. The assessment of Tribal emergency response capabilities were related to terrorist attacks, nuclear, chemical, and biological emergencies. Tribes were selected based on a number of critical criteria, such as proximity to major transportation routes, U.S. borders, nuclear facilities, Department of Defense sites, or Department of Energy sites and other extremely hazardous substances. Information from the preliminary survey indicated that a wide variability of knowledge regarding hazards and response scenarios existed throughout Tribal communities. Some Tribes are better equipped and have more comprehensive emergency response programs than other

Tribes. Currently, there are eight states with 29 Tribal lands having international borders; these areas could be described as “entrances of free passage” for terrorists.

The survey results will provide information on Tribes’ risk level, emergency response infrastructure, and the relationship with surrounding counties. The additional benefit will be to support surrounding non-Tribal communities, especially if the Tribe is the primary government entity available to respond to a major emergency in that region. Also this will allow the agency to compare response capabilities among states, counties, and Tribes, which will be useful in the allocation of resources throughout the country.

The following Tribes will be the first consulted, since they were the originators of the pilot project, if new funding arises to finalize our assessment: Cheyenne River Sioux Tribe (Eagle Butte); Blackfeet; Seneca Nation; United Tribes of the Umatilla (Cayuse, Umatilla, Walla Walla); Navajo Nation; Tohono O’Odham; Choctaw Nation; Santa Domingo Pueblo; and Salish Kootenai (Flat Head Reservation).

In FY05, the ATSDR Office of Tribal Affairs initiated a process to develop a Tribal Emergency Pocket Guide. The Guide is a tool intended to assist Tribal responders and community leaders in their “immediate” (e.g., the first 24 hours) response to emergency incidents, including biological, chemical, and radiological releases. This pocket guide comprises concise checklists, questions, practical considerations, and possible resources to plan a response or to respond to an incident. This tool is intended to augment a Tribal communities’ existing emergency response plan, procedures, guidelines, and resources, as well as serve as a supplement to “CDC’s Public Health Emergency Response Guide for State, Local, and Tribal Public Health Directors.” This pocket guide is general in nature and is not intended to serve as a Tribal community’s emergency response plan, nor should it supersede existing, more technically specific and accurate, local response protocols.

Activity 3: Tribal populations are inextricably intertwined with the environment through multiple uses of resources for food, cultural, ceremonial, and religious practices. This results in environmental exposure scenarios that are unique between Tribes and extraordinarily different from other populations. Also, demographic data indicate that there is a high percentage of AI/AN youth, indicating which represents large vulnerable population. Clinicians that work within Tribal communities receive little, if any, training related to environmental health. Currently training programs of this nature for Tribal Clinicians are lacking. ATSDR developed the Tribal Environmental Health Education Program to improve Tribal Clinicians’ knowledge, skills, and access to resources to identify, prevent, and respond to the health issues related to environmental contaminants. To ensure the final training program will effectively meet the needs of the Tribal Clinicians, ATSDR has presented the program to key audiences and will continue to elicit comments for the training format and administration. Topics covered include a background of ATSDR (including Office of Tribal Affairs, exposure pathways, exposure history assessment, risk communication and major contaminants of concern).

Expected Outcome(s): To raise awareness and build the infrastructure of Tribes to address environmental health issues and threats impacting their community. This will be measured by the amount of resources ATSDR has entering the Tribal community.

Centers for Disease Control and Prevention (CDC)

Priority 1: Funding and Related Issues

Objectives: Manage the CDC fiscal and personnel resources in a manner that maximizes impact on the health and safety of AI/AN people, accurately monitor CDC resources allocated to benefit AI/AN communities, and make this information readily available to Tribal leaders.

Background: In addition to a new strategic focus on health impact, another of CDC's six new strategies is accountability. This means that CDC will work to sustain people's trust and confidence by making the most efficient and effective use of the public's investment in CDC. Improved accountability and better management of resources devoted to AI/AN populations will strengthen CDC efforts to improve public health in Indian Country.

Activities: First, CDC intends to initiate a portfolio management approach to its resources devoted to AI/AN health issues. This approach will improve how CDC tracks and displays its AI/AN resource commitments (see below). Also as part of this approach, CDC will more closely monitor funds distributed to state health departments via CDC grants and cooperative agreements to help ensure that AI/AN communities receive appropriate benefit from CDC funds. Second, CDC will continue to submit to HHS and Tribal leaders an annual Tribal budget and consultation report that includes a summary of CDC resources committed to programs that benefit AI/AN communities. This information will portray fiscal information as committed by CDC's various organizational components and by defined categories. The latter will include a summary of grants and cooperative agreements awarded directly to Tribes and Tribal organizations.

Expected Outcome(s): Better management and improved flow of resources will help to maximize the health impact of CDC programs/projects that focus on AI/AN populations. Increasing transparency in CDC's AI/AN resource allocation process and outcomes will facilitate Tribal awareness of, and participation in, CDC efforts to address Tribal public health issues.

Priority 2: Health Promotion and Disease Prevention

Cancer Prevention

Objective 1: To promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer.

Background: The significant growth of cancer prevention and control programs within health agencies has resulted in recognizing that improved coordination of cancer control activities is essential to maximize resources and achieve desired cancer control outcomes. Comprehensive cancer control results in many benefits, including increased efficiency for delivering both public health-related messages and services to the public.

Activities: All activities are ongoing.

Expected Outcome(s): These efforts will contribute to reducing cancer risk, detecting cancers earlier, improving treatments, and enhancing survivorship and quality of life for cancer patients.

Objective 2: Assist AI/AN women to gain access to lifesaving screening programs for early detection of breast and cervical cancers.

Background: To help improve access to screening for breast and cervical cancers among underserved women, Congress passed the Breast and Cervical Cancer Mortality Prevention Act of 1990, which created CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP). This program provides both screening and diagnostic services, including clinical breast examinations, mammograms, Pap tests, surgical consultation, and diagnostic testing for women whose screening outcome is abnormal.

Activities: All activities are ongoing.

Expected Outcome(s): Many deaths from breast and cervical cancers could be avoided by increasing cancer screening rates among women at risk. Timely mammography screening among women aged 40 years or older could reduce breast cancer mortality by approximately 16 percent compared with women who are not screened. Pap tests can find cervical cancer at an early stage when it is most curable or even prevent the disease if precancerous lesions found during the test are treated.

Diabetes Programs

Objective 1: Get the "Eagle book" series into the hands of young Native children throughout the U.S.

Background: We know that reaching young people, particularly in the school setting where they spend six to nine hours a day, presents an opportunity to help improve the health outcomes of the nation's youth, which, in turn, can have positive effects on intermediate and long-term social, educational, and economic outcomes. The Eagle books and the efforts of CDC's Native Diabetes Wellness Program, in partnership with the IHS and the Tribal Leaders Diabetes Committee (TLDC), are putting those ideas into action by bringing to teachers, parents, and students important health promotion messages to help children grow safe and strong–messages like good nutrition and regular physical activity.

Activities: CDC, IHS, the TLDC, and the author and artists (Georgia Perez, author; Patrick Rolo and Lisa A. Fifield, artists), and First Book, have made it possible to share the Eagle books with AI/AN children throughout the country. First Book, a national non-profit group whose mission it is to put a new book into the hands of every child, is committed to reaching AI/AN children, and through their National Book Bank, we will be able to deliver more than 300,000 books to schools and children.

Expected Outcome(s): Nationwide distribution of the books to children, schools, and communities may help change the dialogue about diabetes prevention to one of hope and respect for community traditions.

Objective 2: Training for a program that provides emotional support to community members with and at risk for diabetes is provided across the country, using a tested "Talking Circles" curriculum.

Background: A culturally-rooted, participatory study, "Diabetes Wellness: American Indian Talking Circles" (Talking Circles), which took place on four reservations in South and North Dakota in recent years, represents an ancient way of gathering Tribal members in a group such as "talking circles," "council fires" and "talkstories." Directed by Dr. Felicia Hodge and implemented by Ms. Loralei DeCora, the project engages families and community members in a process of listening, dialogue, and action to impart wisdom and support for members.

Activities: Community health workers (community health representatives, diabetes outreach workers) in the Aberdeen area have been trained to serve as Talking Circle facilitators in their communities and all interested Tribes in the Northern Plains, and Woodlands in Minnesota, Michigan, and Wisconsin will soon be provided this training. In addition to *Talking Circles* training, community health representatives (CHRs) and diabetes outreach workers will be offered additional tools including, the "Eagle books" for children, "CDCynergy: Diabetes version for American Indian/Alaska Native Communities" (a software package for health communication program development and planning), "Diabetes Atlas" (a geographic information systems tool to assist communities with surveillance and planning), and the DVD curriculum, "The In-Between People: Including Community Health Workers in the Circle of Care."

Expected Outcome(s): Community health workers and other health leaders in Plains and some woodland communities (Aberdeen, Billings, and Bemidji IHS areas) will have the tools and the training to offer "Talking Circles" diabetes curriculum for interested groups in their communities.

Fetal Alcohol Syndrome (FAS)

Objective: Reduce the incidence of FAS in Northern Plains AI/AN children.

Background: Alcohol use during pregnancy continues to be a problem for some AI/AN communities. Programs are needed to educate communities about the effects and prevention of FAS, as well as its identification and management.

Activities: In collaboration with Black Hills State University, Little Wound School on the Pine Ridge Reservation agreed to participate in the pilot testing of a school-based curriculum for students in grades five to eight, based on "Making the Right Choices: A Grade 5-8 Fetal Alcohol Syndrome Prevention Curriculum," developed and used in the Frontier School Division of Canada. In addition, a curriculum was developed and used to conduct a two-day workshop for teachers, juvenile justice workers, and others who might have responsibilities for working with young people with FAS. In collaboration with the University of South Dakota, AI communities in Rosebud, Standing Rock, and Turtle Mountain Chippewa participated in the development of a media campaign to promote a toll-free helpline for women of childbearing age to either reduce their drinking or to increase family planning.

Expected Outcome(s): Trainings/workshops for educators, juvenile justice workers, social service workers, foster care and adoption workers, justice system workers, and others who work with children and youth with FAS and their families, will continue in an effort to improve care for those affected by FAS. A media campaign designed to engage AI/AN women in the project will provide a toll-free number for women to call for support in decreasing alcohol consumption and/or increasing effective contraception use. Also, in FY06, implementation of the surveillance component of the project will occur as well as the tracking system for linking affected individuals with appropriate community services.

HIV Prevention: Native Peoples Alliance

Objective: To promote HIV prevention in AI/AN communities.

Background: From January through September 2005, the National Center for HIV, STD, and TB Prevention's (NCHSTP), Division of HIV/AIDS Prevention (DHAP) continued to work with the Native Peoples' Alliance. The Alliance, which was established in 2004, has been proposed as one of the alliances included in DHAP's National HIV/AIDS Partnership (NHAP) activity.

Activities: NHAP was involved in actively recruiting 11 nationally recognized AI/AN leaders, influential persons, and organizations to promote HIV prevention. NHAP and its partners developed and distributed public service announcements (PSAs), posters with original artwork, ad space in Native American newspapers, and interviews with NHAP messages.

Expected Outcome(s): PSAs, posters, and other messages have reached more than three million AI/ANs through various means and materials were distributed to more than 726,000 persons at 11 national and regional Powwows in 2005. During FY06, CDC expects to continue to promote HIV prevention by recruiting AI/AN leaders and influential persons, investigating sources for external funding for HIV prevention activities, reaching AI/ANs at national and regional Powwows and using PSAs and the media, expanding efforts to reach AI/ANs at Tribal conferences specifically by distributing public health messages and print PSAs to approximately 16,000 persons attending the annual National Indian Health Board and National Congress of American Indians conferences in early FY06.

Immunization

Objective: To help ensure that AI/AN children benefit fully from Vaccine for Children (VFC) services and to accurately monitor immunization coverage/utilization.

Background: In FY05, the VFC program purchased more than $1 billion in vaccines for children birth through 18 years of age who are eligible for the VFC entitlement, which includes all AI/AN children. CDC estimates that 2.43 percent of the U.S. population is AI/AN children zero to 18 years and are VFC eligible. AI/AN children receive VFC services through both IHS and non-IHS providers and facilities.

Activities: Coverage and utilization data for AI/AN populations are monitored through the IHS immunization registry, the National Immunization Survey, and state immunization registries. CDC is working with IHS staff and state immunization registries to develop software to allow the electronic exchange of immunization data between IHS, Tribal, and Urban Indian (I/T/U) health facilities and state immunization registries. The software is currently operational in four states; further expansion is expected.

Expected Outcome(s): The inclusion of immunization data from I/T/U facilities into state immunization registries will improve patient care for this population, allow for more complete information on immunization coverage at the state level to monitor potential disparities, and conserve resources.

Infectious Diseases in Alaska Natives

Objective: Prevention and control of infectious diseases in Alaska Natives

Background: The Arctic Investigations Program (AIP) located in Anchorage, Alaska is one of three U.S. field stations operated by CDC's National Center for Infectious Diseases. Core program activities include; surveillance of infectious diseases, public health research, health communication and education, public health emergency preparedness and response, and bioterrorism preparedness and response.

Activities: AIP maintains a state-wide surveillance system for invasive diseases caused by certain bacteria: S*treptococcus pneumoniae*, *Haemophilus influenzae*, *Neisseria meningitidis*, and Groups A and B Streptococcus. In Alaska, the infant pneumococcal vaccine (PCV7) was introduced in 2001 and disease rates due to vaccine types declined by 85 percent among children under two years of age. However, the adult pneumococcal vaccine remains underutilized. For example, surveillance identified an outbreak among unvaccinated adults for whom vaccine was indicated but not received by 50 percent of outbreak cases. Clusters of invasive *H. influenzae* type A infections have been identified through surveillance among Alaska Natives, and rapid case investigations/interventions are linked to an intact surveillance system. *N. meningitidis* remains an important cause of bacterial meningitis for which a new vaccine has recently been introduced. Surveillance data indicate that 57 percent of early-onset group B streptococcus (GBS) cases in Alaska were preventable through use of national guidelines for prenatal screening and treatment. These findings promoted an educational effort by AIP and the Alaska Department of Health and Social Services to increase awareness among Alaska healthcare providers regarding appropriate diagnosis and treatment of perinatal GBS disease. Surveillance is needed to determine whether this education can reduce rates of GBS disease.

Expected Outcome(s): Vaccine policies and programs need ongoing high quality data collection to be responsive to changes in disease trends. With continued surveillance for these diseases, AIP will assess vaccine program effectiveness, monitor for the emergence of bacterial types not covered by current vaccines, and test for the development of drug resistant strains. The impact of the newly introduced vaccine against *N. meningitidis* will be determined through disease surveillance.

Injury Prevention

Objective: To design, implement, and evaluate AI/AN community-based interventions with demonstrated effectiveness for preventing motor vehicle injuries within the following areas: strategies to reduce alcohol-impaired driving among high risk groups; strategies to increase safety belt use among low-use groups; and strategies to increase the use of child safety seats and booster seats among low use groups.

Background: The leading cause of death among AI/ANs is unintentional injuries caused by motor-vehicles. The initial funding year for this program began in 2004.

Activities: CDC's National Center for Injury Prevention and Control funds $71,480 annually for four years to four Tribes (Ho-Chunk Nation, White Mountain Apache Tribe, Tohono O'odham Nation, and San Carlos Apache Tribe) to develop, implement, and evaluate a tailored community-based intervention with demonstrated effectiveness to reduce motor vehicle-related injuries among AI/AN.

Expected Outcome(s): For each Tribe to reduce injury and deaths due to motor vehicles and to increase seat belt and booster seat use.

Reproductive Health (RH)/Maternal-Child Health (MCH)

Objective: To carry out activities in epidemiology, surveillance, capacity building, and enhanced data utilization and dissemination that lay the groundwork for improvements in reproductive and maternal-child health among AI/ANs.

Background: In FY04 and 05, CDC's Division of Reproductive Health (DRH) modified its approach to AI/AN health, implementing and supporting more activities that are aimed toward expanding and improving AI/AN RH/MCH in the United States. The new approach has focused on helping to overcome obstacles to such activities and assisting Tribal organizations to make RH/MCH improvements.

Activities: DRH convened a meeting of experts in MCH among AI/AN in the spring of 2004 with the goal of raising awareness of the need for enhanced research into this much neglected area. This meeting has led to a number of follow-up activities inside and outside DRH. One such activity is the production of a special issue of the Maternal and Child Health Journal that will help publicize AI/AN MCH disparities and develop publication capacity among AI/AN researchers. DRH researchers are studying the effects of smokeless tobacco on pregnancy outcomes in Alaska Native women. DRH staff has explored potential applications of IHS clinical data in the area of maternal and infant health and have conducted a study of maternal morbidity in IHS facilities using such data. DRH is also playing a lead role in a new international initiative regarding the measurement of health indicators in indigenous populations. Other activities include working with AI groups to improve and standardize death scene investigations for SIDS deaths, working with Tribal Epi Centers to use data to create positive change in Tribal communities, and providing technical assistance in South Dakota to investigate reported excess molar pregnancies.

Expected Outcome(s): Enhanced research and surveillance activities on MCH and reproductive health among AI/AN, in both basic epidemiology and programmatic issues, improved capacity of Tribes and Tribal organizations to carry out and publish research in RH/MCH, successful epidemiologic studies in this area, improved utilization of MCH data collected by IHS, and improved understanding of measurement issues and how data can be improved in RH/MCH among AI/ANs.

STD Prevention and Control

Objective 1: To develop a National Coalition of STD Directors (NCSD) sub-committee to better address STD prevention and control efforts among AI/ANs.

Background: In 2004, CDC and the IHS National STD Program recommended to NCSD that it form a subcommittee of state STD Directors from states with large AI/AN populations to better address STD prevention and control efforts among AI/ANs. NCSD accepted the paper and voted to form this subcommittee in early 2005.

Activities: The AI/AN subcommittee is currently co-chaired by the STD Directors of Minnesota and Utah and has approximately 15 members. Following an organizing meeting in January 2005, IHS and NCSD, with CDC assistance, entered into a Memorandum of Agreement whereby IHS will support NCSD in hiring a contractor to operationalize and support many of the subcommittees' efforts.

Expected Outcome(s): The NCSD AI/AN subcommittee will facilitate improved education of Federal, state, and local policymakers about issues relevant to STD prevention and control measures in AI/AN populations and will foster stronger partnerships between Tribal and state public health programs. These partnerships should lead to the creation of public health and Tribal networks that can serve not only the STD issue well, but also other public health issues and emergencies.

Objective 2: To improve STD prevention and control activities in Indian country through improved collaboration between CDC, IHS, and Tribal, state, and county health programs.

Background: CDC and the IHS National STD Program collaborated to plan and convene a series of regional STD summits to bring together CDC, IHS, Tribes, States, and counties to develop collaborative strategies to improve STD prevention and control activities in Indian Country.

Activities: The first summit was hosted by the Alaska Native Epidemiology Center in Anchorage, Alaska in January 2005. Summit participants included representatives from public and private organizations across the state. Topics included a presentation of STD epidemiological data, an overview of the Alaska health system, Tribal perspectives on STDs, reporting issues, partner notification issues, new testing technologies, and training opportunities. The second summit took place in Farmington, New Mexico in June 2005 and focused on Tribes in the Four Corners region of the United States. More than 100 people attended, representing IHS and Tribal/state/county governments. In addition to basic topics on STD and HIV prevention, transmission, and treatment, there was a special facilitated strategy session.

Expected Outcome(s): Improved collaboration between CDC, IHS, Tribal, state, and county entities addressing STD prevention and control should lead to decreased incidence of STDs among AI/Ans.

Violence Intervention

Objective: To create partnerships with communities to support the delivery of intimate partner violence interventions to prevent intimate partner and sexual violence and services for AI/AN communities.

Background: This is a new program with a project period of three years and is intended to assist racial/ethnic minority communities to assess and prevent sexual and intimate partner violence.

Activities: CDC's National Center for Injury Prevention and Control funds the National Indian Justice Center $150,000 annually to build capacity for Native American communities to prevent intimate partner and sexual violence. There will be an emphasis to work with men and boys in a culturally appropriate manner to prevent these forms of violence before they occur.

Expected Outcome(s): To support the development, implementation, and evaluation of culturally competent demonstration projects for early intervention of both sexual and intimate partner violence.

<u>Priority 3: Recruitment and Retention of Healthcare Providers</u>

<u>Professional Clinical Skills Development</u>

Objective: To train mid-level providers to perform flexible sigmoidoscopy in IHS and Tribal health facilities.

Background: This is the second of a two-year CDC–IHS Intra-Agency Agreement.

Activities: Activities that have occurred thus far include curriculum development for trainees, purchase of screening equipment, training of three mid-level practitioners from Kotzebue, Klawock, and Juneau at the Alaska Native Medical Center; brochure of training program developed; abstracts about the program submitted/accepted for the American Public Health Association; Inuit Rural Health Conference; and the Alaska Public Health Summit; baseline rates established in all areas for trainee regions; and participation in the development of RPMS-based tracking systems.

Expected Outcome(s): It is anticipated that screening rates for colorectal cancer will increase for the Alaska Native population based on increased access to these services.

<u>Priority 4: Emergency Preparedness</u>

<u>Communicable Disease Control</u>

Objective: To revise Federal communicable disease (quarantine) regulations.

Background: The Federal regulations that implement CDC's statutory authorities for communicable disease control are in the Code of Federal Regulations (42 CFR, Parts 70, 71). These regulations, which have not been updated in many years, contain no specific provisions regarding Indian Country.

Activities: During FY05, CDC initiated a Tribal consultation process regarding the proposed revisions that included presentations at HHS Regional Tribal Consultation Sessions and the distribution of a Dear Tribal Leader letter from Directors of CDC and IHS. These activities served to advise Tribal leaders about the formal release of revised draft regulations in a Notice of Proposed Rule Making (NPRM).

Expected Outcome(s): The NPRM containing the proposed revisions was released for Tribal and public comment early in FY06. Tribal leaders' comments will be collected and specifically addressed as part of CDC's newly established Tribal consultation procedures. With Tribal input, the new regulations should specifically and effectively address the application of these regulations in Indian Country.

Cross-Border Preparedness

Objective: To establish cross-border emergency preparedness partnerships with First Nations (FN) and Health Canada.

Background: Communities located on or near international frontiers face unique jurisdictional and organizational challenges when planning for, or responding to, health crises such as pandemic influenza, outbreaks of other infectious diseases, or bioterrorism events.

Activities: The Early Warning Infectious Disease Surveillance (EWIDS) project is working to enhance surveillance and epidemiological capabilities at the U.S. northern and southern borders, with emphasis on creating interoperable systems with Canada and Mexico. States along the Canadian border participating in EWIDS have initiated discussions with AI/AN and FN representatives, Health Canada, and provincial partners to support preparedness for AI/AN and FN communities and to ensure their participation in Federal-state-provincial planning activities. CDC intends to convene a planning meeting to bring together representatives from U.S. state and Tribal governments, First Nations, and Health Canada to explore expanding collaborations to address cross-border terrorism and emergency preparedness initiatives.

Expected Outcome(s): The proposed meeting will help to create a greater awareness of the on-going challenges to effective emergency preparedness and response faced by AI/AN and First Nations communities located on or near the U.S.–Canadian international frontier. A priority for the meeting will be to clearly define these challenges and propose solutions and partnerships to address them.

Priority 5: Data and Research

Objective: Compare levels of organochlorine compounds in Alaska Native women who have breast cancer and those who do not have breast cancer.

Background: Dietary practices may place ANs at increased risk of exposure to organochlorine compounds. These compounds are being evaluated for a possible role in development of breast cancer.

Activities: Methodology for analyzing organohalogen compounds in breast adipose tissue will be evaluated and certified. Then the 229 adipose tissue sampled will be analyzed for brominated flame retardants, polychlorinated biphenyls, and persistent pesticides. This project will be completed in 2006.

Expected Outcome(s): The ultimate goal of the project is to enhance primary prevention of breast cancer by evaluating the environmental risk factors for this disease.

Infectious Diseases in Alaska Natives

Objective: To reduce the morbidity and mortality of diseases caused by *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Helicobacter pylori*, methicillin resistant *Staphylococcus aureus* (MRSA) and Hepatitis B virus.

Background: In Alaska, several infectious diseases require new knowledge and techniques to improve prevention and control strategies. High rates of invasive *S. pneumoniae* infections among Alaska Natives have been complicated by increased antimicrobial resistance. Pneumococcal conjugate vaccine (PCV7) use has reduced disease rates and drug resistance among invasive infections; however, the long term impact upon resistance and disease rates is uncertain. Prior to infant vaccine use, Alaska's *H. influenzae* type b (Hib) rates were the country's highest. Despite successful vaccination programs and a 90 percent drop in disease, Hib rates remain higher in AN children than non-Natives. Further effort is needed to reduce this health disparity and meet the objective of elimination of Hib disease. *Helicobacter pylori* infections, occurring in up to 80 percent of ANs, are a cause of gastric ulcers and cancer. Antimicrobial resistance complicates treatment and contributes to high reinfection rates. The role played by *H. pylori* in the 3-fold increased risk of gastric cancer among ANs remains to be determined. Emerging MRSA causing skin infections among ANs has presented challenges for prevention and control. The high rate of pneumonia hospitalization of young children in rural Alaska remains a problem despite advances in vaccines and health care access.

Activities: AIP is working to characterize the effect of PCV7 vaccine use on disease rates, antimicrobial resistance, and colonization, to evaluate the 23-valent polysaccharide vaccine by determining antibody response among revaccinees, and to develop standardized methods for detecting and quantifying total and functional serotype antibody. Research activities directed toward *H. influenzae* include monitoring the effects of Hib vaccine on disease rates, including emergence of non-vaccine types; responding to new cases of invasive disease by rapidly assessing risk factors and colonization; and developing standardized molecular methods for the detection, serotyping, subtyping and characterization of virulence factors. AIP's *H. pylori* research seeks to determine risk factors for reinfection after treatment, monitor antimicrobial resistance patterns among clinical isolates, develop antibody assays for organisms with high virulence, and develop strategies to assess risk factors for gastric cancer among ANs. For MRSA infections, AIP is working to establish surveillance in S.W. Alaska and Anchorage, develop molecular methods for the subtyping and characterization of antimicrobial resistance and virulence factors, and assess community perceptions of potential prevention strategies. AIP is also conducting studies to determine if persons receiving Hepatitis B vaccine remain protected after 23 years and if children vaccinated as infants retain immunity as teenagers.

Expected Outcome(s): These activities will support and inform the development of vaccine policy to reduce disease incidence; help to rapidly identify *H. influenzae* cases and determine factors that could be used to reduce disease rates; identify risk factors for re-infection for *H. pylori* to improve outcomes among persons undergoing treatment; educate Alaska Natives in affected areas about MRSA prevention strategies and educate healthcare providers about treatment and prevention of MRSA infections; and use data on duration of Hepatitis B vaccine effectiveness to inform vaccine policy regarding the need or booster doses. Ongoing laboratory research and development, particularly that in support of epidemiologic studies important to ANs, will also build AIP's capacity to rapidly detect, identify, and respond to any new infectious disease threats.

Smoking Cessation in Alaska Native Women Study

Objective: Increase smoking cessation among Alaska Native (AN) women.

Background: Alaska Natives have the highest smoking rate during pregnancy of any ethnic group. AN leaders are aware of this problem and are committed to changing it. This study is a planned intensive smoking cessation effort to be undertaken as part of the Smoke-Free Families initiative to stop smoking during and beyond pregnancy. The study will involve approximately 500 women who will be evaluated and counseled at their first prenatal visit, and again at the 6th and 8th month of pregnancy. Previous studies of smoking cessation during pregnancy have confirmed that biomarkers, such as cotinine measurements, are essential for accurate assessment of the results.

Activities: CDC will provide analyses of biomarkers to ensure accurate assessment of study results. These data will also provide needed new information on the extent of exposure, based on biomarker analysis, in this population. During FY05, we completed an initial pilot study of this project.

Expected Outcome(s): Identification of smoking cessation facilitators and barriers among AN women.

Smokeless Tobacco Use by Alaska Natives

Objective: To study the health effects of iq'mik, a form of smokeless tobacco used by Alaska Natives.

Background: Alaska Natives in specific remote locations use a form of smokeless tobacco called iq'mik, a combination of tobacco and punk tree ash, which is likely used to increase nicotine bioavailability by altering the pH of the material. Iq'mik is widely used by infants to lessen teething pain and by pregnant women as an alternative to smoking. Both of these uses have been well educated concerning the risks.

Activities: CDC is working with Alaska Native groups to develop information on the product and its effects in people that can then be used in educating AN communities about the threats of adverse effects from the use of iq'mik. During FY05, CDC developed plans and protocols for this study; CDC also has obtained iq'mik samples to assess levels of toxic and addictive compounds. In FY06, CDC will continue laboratory analyses of iq'mik products to inform educational efforts on this product.

Expected Outcome(s): Increased scientific understanding of the harms of iq'mik use and enhanced awareness of risk among Alaska Native people.

STD Prevention and Control

Objective: To improve the relevance of national STD surveillance data for Indian country.

Background: The IHS system of records provides a rich source of health data for approximately 56 percent of the total U.S. AI/AN population. IHS health data primarily focus on population statistics, birth/death data, and patient care utilization. Data on STDs and other nationally notifiable diseases are lacking, yet these diseases represent a significant burden on the IHS healthcare system. STD surveillance data reported to CDC are typically available only at the county, state, or national levels. IHS administrative areas, however, are made up of groupings of select counties from select states. New approaches and methodologies are needed to better manage and analyze Federal data sources that support public health programs in Indian Country.

Activities: CDC and IHS National STD Program staff collaborated with statisticians from both agencies to improve AI/AN STD surveillance methodology, whereby CDC's nationally compiled STD data are coded and presented using population parameters based on IHS administrative regions (Areas and Service Units). A final report focusing on chlamydia, gonorrhea, and syphilis will be prepared in FY06.

Expected Outcome(s): This approach to analysis of surveillance data will improve the accuracy of STD epidemiologic data for AI/ANs, and may serve as a model for addressing similar issues for other reportable diseases, such as hepatitis and tuberculosis.

Centers for Medicare and Medicaid Services (CMS)

Priority 1: Medicare Part D Prescription Drug Coverage

Objective: To implement the Medicare prescription drug coverage in Indian County. This will entail educating both I/T/U providers and beneficiaries about the coverage and taking necessary steps to get providers and beneficiaries to participate in the program.

Background: The Medicare Modernization Act included provisions to provide outpatient prescription drug coverage to all Medicare beneficiaries. CMS was tasked with getting the program operation within a very short timeline. To implement the new coverage, beneficiaries, providers, caregivers and others have to be educated about the availability of the benefit to help them make informed decisions about participating in the program. This issue was given priority by CMS and the TTAG during 2005.

Activity 1: To help Tribal communities implement the program, the TTAG passed a resolution outlining actions CMS should take to ensure that the new coverage is available in Tribal communities. Among other things, the TTAG requested that CMS provide at least two trainings for providers and relevant health care administrators in the community, that culturally appropriate materials be developed, and I/T/U pharmacies be allowed to participate in the prescription drug plans on equal footing with other providers.

Activity 2: CMS worked with the IHS and TTAG to develop contact addenda to ensure that willing IHS and Tribal providers would not be adversely impacted when plans selected providers to participate in their networks. This special language should appear in all part D contracts offered to Tribes.

Activity 3: CMS partnered with IHS and SSA to conduct AI/AN specific outreach and education for Medicare Part D. This was one part of a large effort to inform Indian Country about Medicare Part D. Two trainings were held for each of the 12 IHS Area offices on awareness and general outreach and comprehensive, train-the-trainer sessions.

Activity 4: Other outreach activities were conducted including: provision of culturally specific materials for beneficiaries and providers; Open Door Forums; a contract with the National Indian Council on Aging for face to face outreach to AI/AN beneficiaries; and an Interagency Agreement with the IHS Urban Indian health program for specific urban Indian health outreach. Our Region's Native American Contacts continue to train and inform Indian health providers about the new prescription drug program.

Expected Outcome(s): We expect that these efforts will result in increased enrollment of AI/ANs in Medicare's prescription drug coverage. This, in effect, will permit scarce I/T/U funding to be stretched since Medicare will pick of the tab for these drugs and funds, previously paid by IHS to cover these drugs, will now be available to provide other health care services.

Divisions and other Groups Involved in Addressing Priority: IHS, SSA, TTAG, Tribes

<u>Priority 2: Appointment of a Tribal member to Medicaid Commission under Public Law 92-463</u>

Objective: Appoint an AI/AN as a voting member on the Medicaid Commission

Background: During various regional consultation sessions as well as CMS' discussions with the TTAG, it was expressed that Indian Country should have at least one seat on the Medicaid Commission. The Northwest Portland Area Indian Health Board (NPAIHB) and Affiliated Tribes of the Northwest (ATNW) also adopted a letter transmitted to Secretary Leavitt requesting consideration to appoint an AI/AN to serve as a voting member of the new Medicaid Commission.

Activity: Letter transmitted to Secretary Leavitt

Expected Outcome: AI/AN serves on the Medicaid Commission as a voting member

Divisions and Other Groups Involved in addressing Priority: HHS, TTAG, NPAIHB, CMS, ATNW

Priority 3: Policy Guidance for Medicaid Administrative Matching (MAM)

Objective: Written policy regarding Tribal Organizations' participation in MAM

Background: MAM guidelines allow Tribes to receive the Federal share of Medicaid reimbursement for the costs of Medicaid administrative activities preformed in settings that promote cultural sensitivity. According to CMS regulations, Tribal governments are eligible to participate in these contractual arrangements. Tribes requested that CMS clarify and consolidate guidance on meeting statutory and regulatory requirements in the context of Tribally operated health programs.

Activities: The TTAG established a MAM Subcommittee and asked CMS to develop a Dear Medicaid Director decision letter. CMS continues to have discussions with IHS, Tribes and states regarding development and implementation of CMS policy related to approved contracting requirements.

Expected Outcome(s): A state Medicaid Director's letter and Dear Tribal leader letter containing written guidance to States, Tribes, and Tribal organizations participating in MAM arrangements.

Divisions and Other Groups Involved in Addressing Priority: TTAG, CMS, IHS, OGC, California Rural Indian Health Board, NPAIHB, Washington State American Indian Health Council

Priority 4: Medicare Like Rates: Section 506 of the Medicare Modernization Act

Objective: Expedite clearance of regulations for publication in the *Federal Register*

Background: Section 506 of MMA requires Medicare hospitals to collect no more from IHS or Tribes than Medicare rates established by the Secretary. "Medicare-Like Rates" would be established as payment in full for services provided to Indian patients referred by IHS and Tribally operated Contract Health Services programs (CHSP). This new law extends to Indian health programs the same type of nationally negotiated rates used by the Veterans' Administration and the Department of Defense. The TTAG is seeking expeditious publication of the rule.

Activities: The TTAG provided advice to IHS and CMS that was considered in development of the proposed rule. The proposed rule is now in the clearance process. The TTAG requested that the regulation be issued as an interim final rule.

Expected Outcome(s): Expeditious approval of the regulation and publication in the *Federal Register*

Divisions and Other Groups Involved in Addressing Priority: HHS, CMS, IHS, TTAG

Priority 5: Equitable Relief

Objective: Waive the Part B premium surcharge for AI/ANs enrolling late into Medicare.

Background: On July 1, 2001, Congress granted IHS authority to bill for Medicare Part B services. Since that time, IHS has requested that CMS waive the Medicare Part B premium surcharge for late enrollment for all AI/ANs not currently enrolled in Part B. The waiver is being sought because beneficiaries were advised by IHS employees and Tribal leaders not to enroll in Part B because IHS would cover their medical bills. IHS has stated that employees providing this advice were acting as agents on behalf of CMS pursuant to interagency agreements (IAAs) between the agency and CMS, and believes that a waiver would be possible. Medicare law provides that organizations may pay for Part A and B premiums on behalf of beneficiaries by establishing a formal group billing arrangement with CMS. Tribal groups may enter into a formal group payer agreement as long as certain requirements are met. Many Tribes already participate in this program but most are not prepared to pay the additional surcharge penalty.

Activities: 1) The Salish Kootenai Tribe and NPAIB have inquired as to whether Tribes can pay Tribal members' premiums and surcharges, and if CMS will consider a waiver of the surcharges for Tribes similar to the waiver granted to State and local government employer groups and the military. 2) CMS prepared a decision memo that describes this issue in more detail. The memo acknowledges that IHS employees were acting as agents on behalf of CMS pursuant to Interagency Agreements, and the surcharge be waived on a case-by-case basis for those AI/ANs who received erroneous advice from IHS employees while the IAAs were in effect. These individuals would request equitable relief when they enroll in Part B. Section 1837(b) of the Social Security Act provides for equitable relief with appropriate adjustment of premiums when an individual's enrollment or non-enrollment in Part B is the result of government error.

Expected Outcome(s): Waiver of the Medicare Part B premium surcharge to permit Tribes to pay premiums on behalf of their members.

Divisions and Other Groups Involved in Addressing Priority: HHS, CMS, IHS, NPAIHB, Salish Kootenai Tribe, Sates State Health Insurance Benefits Advisors, AoA, TTAG

<u>Priority 6: Federal Supply Schedule</u>

Objective: To reissue guidance to permit IHS to bill third party payers such as Medicaid for drugs issued under the Federal Supply Schedule (FSS).

Background: This issue has been pending since early 2002. In February and again in March 2002, CMS issued guidance through the "Drug Rebate Bulletin" to state Medicaid programs that CMS had been advised by the Department of Veterans' Affairs that Drugs issued under the FSS should not be billed to a third-party payer such as Medicaid. IHS is mandated to purchase drugs through the FSS. This CMS guidance was later found to be incorrect. CMS has not yet issued a retraction and continues to have concerns about the appropriate rate for Medicaid programs to pay IHS for covered prescription drugs. Currently, States pay IHS in a variety of ways with approximately half paying an all-inclusive rate, which is interpreted by some to be payment at a profit and therefore prohibited. The retraction needs to move forward and the profit concerns need to be addressed.

Activities: The TTAG has established a subcommittee to assist CMS in development of its retraction. CMS Medicaid staff is continuing to work to develop the response to these issues.

Expected Outcome(s): New CMS guidance to permit IHS to bill Medicaid for drugs purchased from the FSS.

Divisions and Other Groups Involved in Addressing Priority: TTAG, CMS, IHS, VA

<u>Priority 7: Medicaid Payments for Services Provided Across a State's Border</u>

Objective: Address a barrier to I/T/U facilities receiving Medicaid payments for services provided to patients who do not reside in the state where the facility is located

Background: This issue was identified through Tribal consultation in 1999 as a barrier for Indian health facilities receiving Medicaid payments. The Indian Medicaid patient population, for reasons often beyond their control, access services at facilities outside their home state, i.e., in youth regional treatment centers and Indian boarding schools, or they have to travel to access services at an Indian health facility not available in their home state. Youth regional treatment centers are required to accept patient from other states and Indian boarding schools house students from a variety of states. However, each facility is finding it difficult to obtain payments for out-of-state Medicaid patients even though Medicaid payments for services provided through IHS facilities are covered by 100% FMAP and state funds are not involved.

Activities: The CMS TTAG has established a Subcommittee to address this issue. Meetings were held, but the issue has not yet been resolved. The State Medicaid representative from Oklahoma who sits on this Subcommittee discussed an agreement that the Choctaw Nation has in place for obtaining Medicaid payments from other states in the Dallas Region. The Arizona Medicaid Representative gave the subcommittee a website for a model agreement it has in place to address cross state border cases. Additional work needs to be done to address this issue on a national basis.

Expected Outcome(s): Develop national guidance to encourage states to make Medicaid payments to these facilities when AI/ANs cross state borders to receive care in these facilities.

Divisions and Other Groups Involved in Addressing Priority: Workgroup members: TTAG, CMS, IHS, American Public Human Services Association, National Association of State Medicaid Directors

Priority 8: CMS Consultation Policy

Objective: Develop CMS Consultation Policy Statement

Background: Per the HHS revised consultation policy, each operating division has to revise its policy to comply with the Departmental policy. CMS choose to use the TTAG to develop its consultation policy.

Activities: The TTAG established a Consultation Policy Subcommittee to develop its new policy. The Subcommittee submitted its proposed consultation policy to CMS for preliminary review in August. CMS has reviewed the proposal and made revisions. The TTAG will conduct Tribal consultations on the proposal in 2006 to ensure that the CMS policy is reflective of the Tribal community's input.

Expected Outcome(s): A consultation policy that is feasible for CMS and approved by the Tribal community.

Divisions and Other Groups Involved in Addressing Priority: TTAG and TTAG Consultation Policy Subcommittee, CMS, OGC, IHS

Priority 9: CMS Strategic Plan

Objective: Develop a CMS strategic plan

Background: The TTAG noticed that prior to its existence a number of Tribal issues were pending action within CMS. They also noticed that many issues continued to languish even after the establishment of the TTAG, and TTAG members were concerned that there was no process for addressing or determining which issues remain priorities for Tribal communities. The TTAG was further concerned that many of the Tribal issues remained unaddressed because very few staff had knowledge of the I/T/U health care system or how Indian health impacts CMS' programs. Hence, the TTAG asked CMS Administrator Dr. McClellan to permit them to develop a strategic plan for CMS to help establish Tribal priorities and establish an approach to address Tribal issues. In FY04, $150,000 was granted to the TTAG through the NIHB to develop a preliminary strategic plan.

Activities: In April, the TTAG submitted to CMS Part 1 of the strategic plan, which outlined three key issues facing CMS and Tribes including the need for improved CMS capacity to develop policy for Indian Country, MMA implementation, and Medicaid reform. In July, CMS provided TTAG, through the NIHB, $52,000 to complete the strategic plan. Part 2 of the plan, released to CMS in August, includes recommendations impacting revision of CMS' consultation policy and improving AI/AN access to CMS programs and services. Part 3 of the plan will address prioritization of issues including trainings through CMS satellite network, AI/AN related research and evaluations and focus will be given to addressing unresolved Tribal issues pending within CMS.

Expected Outcome(s): More effective, responsive and timely system for CMS to use in addressing Tribally-related issues, and a better sense of Tribal priorities.

Divisions and other Groups Involved in Addressing Priority: CMS, TTAG

Priority 10: Durable Medical Equipment (DME)

Objective: Establish DME Guidance for I/T/Us.

Background: CMS has developed guidance to Fiscal Intermediaries to implement the DME benefit for I/T/Us as required by MMA section 630 (Part B), effective January 1, 2005. Currently, guidance is in place of non-hospital based facilities. CMS is seeking input on which hospitals and I/T/U provider types might be interested in billing the DEMERC and will describe the DME supplier criteria and the process for obtaining a supplier number.

Activities: The TTAG has established a DME Subcommittee to address this issue.

Expected Outcome(s): Criteria that various I/T/U providers-types can use to bill for DME and obtain a supplier number.

Divisions and Other Groups Involved in Addressing Priority: TTAG, CMS, IHS

Health Resources and Services Administration (HRSA)

Priority 1: Health Professions Recruitment

Objective: To expand and improve access to care for AI/AN people and other underserved populations.

Background: For more than 30 years, the National Health Service Corps (NHSC) has assisted underserved communities to recruit and retain primary care, oral, and mental and behavioral health clinicians. Through scholarships and loan repayments, NHSC enables health professionals to go where others choose not to go and helps communities meet the health care needs of their vulnerable populations. Historically, NHSC has not allowed its loan repayors to work in I/T/U facilities. Loan repayors along with scholars are required to work in clinical settings with an established health professions shortage area (HPSA) score; many of the I/T/U facilities do not have these scores. While in the I/T/U facilities, NHSC must have the ability to monitor the clinician; this was met with some opposition previously. The Health Professions workgroup is confident that through the collaboration there will be increased communication and resolution regarding these issues and is strongly committed to the shared monitoring of clinicians and outcome measures along with the enforcement of NHSC policies and regulations.

Activities: 1) Conduct meetings to resolve the coordination of NHSC Loan Repayors (LRP) awards so that LRP participants can work at I/T/U facilities. 2) Work with Tribal facilities to provide technical assistance to establish HPSA scores. Sites still having a difficult time with key elements needed to establish population designations. 3) Attempt to get all 550 recognized Tribal sites in the Shortage Designation Branch (SDB) online query. SDB has identified the I/T/U Program Directors and a list has been disseminated to workgroup members.

Expected Outcome(s): To recruit Native American recipients as new scholars and new loan repayors.

Divisions and Other Groups Involved in Addressing Priority: IHS

Priority 2: Emergency Preparedness

Objective: To ensure increased access to emergency medical services for children (EMSC) resources aimed at underserved populations, including AI/ANs.

Background: EMSC grants fund States and U.S. Territories to improve existing emergency medical services (EMS) systems and to develop and evaluate improved procedures and protocols for treating children. Currently, only State governments and accredited schools of medicine are eligible to receive EMSC grants. States receive as much as $115,000 per year, for as many as 3 years.

Activities: Provide funding for EMSC State Partnership grants and require that at least 10 percent is aimed at AI/AN populations.

Expected Outcome(s): Ensure that pediatric health needs are addressed in state disaster plans.

Divisions and Other Groups Involved in Addressing Priority: None

Priority 3: Health Promotion Disease Prevention

Objective: To strengthen operations of existing health centers and I/T/U Indian Program organizations.

Background: Since Tribes have identified diabetes, cancer, and cardio-vascular disease as specific concerns, the Bureau of Primary Health Care (BPHC) is addressing health disparities for Indian people through its primary care programs. In October 2004, a Health Disparities workgroup was formed with HRSA and IHS to expand access to quality primary and preventive health care and to strengthen the operations of existing health centers and I/T/U Indian Program organizations.

The Health Disparities workgroup began with the most immediate goal of expanding access by increasing the number and quality of applications for 330 funding from I/T/U organizations. Another area of focus was sharing best practices in the area of clinical quality. HRSA and IHS collaborated on lessons learned from Electronic Health Record implementation and sharing best practices from the nationally recognized work of the HRSA Health Disparities Collaboratives, particularly those participating health centers caring for more than 20% Native American populations having experienced decreases in health disparities.

Activities: 1) Ensure that increased numbers of health center teams are working with AI/ANs in various collaboratives. 2) Provide increased technical assistance with Tribes.

Expected Outcome(s): Health outcomes of AI/ANs will improve and be sustained over time.

Divisions and Other Groups Involved in Addressing Priority: IHS

Substance Abuse and Mental Health Services Administration (SAMHSA)

Priority 1: Increased Access to HHS Grants; Health Promotion and Disease Prevention

Objective: To ensure Tribes and Tribal organizations receive technical assistance in relation both to SAMHSA's grant opportunities and infrastructure development; the Agency focuses efforts on increasing the number of grants received by Tribal entities; and substantial activities of the Agency are devoted to helping Tribal entities with health promotion and disease prevention, including suicide prevention.

Background: With a view toward increasing Tribal access to the Agency's grants, the SAMHSA Administrator expanded the eligibility policy for Tribal entities (effective beginning in FY05) in relation to SAMHSA grants. Henceforth, Tribal entities are to be eligible for all grants for which States are eligible unless there is a compelling reason to the contrary (such as legislative requirements pertaining to block grants). Any reason for excluding Tribal entities from grant eligibility needs to be justified and approved by the Administrator. The narrative for this Tribal priority segment combines increased grant access with health promotion and disease prevention. It covers technical assistance made available to Tribal entities in FY05 and significant grant awards made during the year. SAMHSA's grants variously cover mental and substance abuse disorders, including co-occurring disorders, prevention, and treatment. This segment also implicitly includes the Tribal priority of funding issues, since a major emphasis by Tribes at the consultation sessions is to increase the amounts of funding from HHS Divisions.

Activity 1: Technical Assistance to Tribes

The Center for Substance Abuse Prevention (CSAP), in collaboration with the Center for Substance Abuse Treatment (CSAT), awarded a $3 million, three-year cooperative agreement to the American Indian/Alaska Native National Resource Center for Substance Abuse Services (One Sky Center) to improve prevention and treatment of substance abuse among Native people. Now in its third and final year, the objectives of the Center include identifying culturally appropriate best practices in substance abuse prevention science and treatment services designed for AI/ANs; facilitating the implementation of evidence-based preventive programs and care systems for Native people; providing continuing education in substance abuse prevention and treatment to enhance the capabilities of educators and clinicians serving AI/ANs; and recruiting Native youth into education and health care training programs aimed at prevention and treatment of chemical dependency. CSAP sponsors two technical assistance projects that serve Tribal grantees and organizations. These are the Coalition Institute, which serves all the Coalitions under the Drug Free Communities Support Program, and the Centers for the Application of Prevention Technologies (CAPTs), which serves Tribal and State recipients of CSAP funding.

Each year, SAMHSA provides a series of community- and faith-based technical assistance sessions and trainings throughout the country, aimed particularly at helping attendees with the application process for SAMHSA grants. A key session, held specifically for Tribes and much broader in scope than other sessions, is the "Annual Indian School on Alcohol and Other Drug Related Issues." It is run by the American Indian Training Institute and is sponsored by SAMHSA.

Activity 2: FY05 Grant Awards to Tribes

Child/Adolescent Mental Health: Under the Child Mental Health Initiative, SAMHSA awarded a total of $2,469,000 to three new Tribal entities in order to treat children diagnosed with a Severe Emotional Disturbance (SED). One grantee, the Blackfeet Tribe, will create the Po'ka Project, which will implement the systems of care philosophy at the Tribal level and identify, plan, and enhance coordination, and to facilitate a wrap-around process that will enable children with SED and their families to access services. Other new grantees include the Yankton Sioux Tribe and the California Rural Indian Health Board.

SAMHSA awarded a $400,000 grant to Wakanyeja Pawicayapi, Inc. to serve children and youth aged 3-18 who have experienced trauma on the Pine Ridge Indian Reservation. Lakota children and youth experience traumatic events at much higher rates than the general population in the United States, but resources for treating trauma are seriously limited in quality and scope. Among the services the grantee provides are culturally based mental health interventions for children and youth diagnosed with SED.

In FY05, a new contract entitled "Native Aspirations" funded a $1,000,000 effort to provide proactive mental health assistance to children, youth, and their families living in Alaska Native villages. The goal of this contract is to decrease the risk factors that contribute to school violence and suicide, and increase the protective factors that are linked to the healthy and safe development of children and their families.

Emergency Response: SAMHSA was quick to respond to the emergencies at Red Lake and Standing Rock which involved violence and suicides. A SAMHSA Emergency Response Grant (SERG) for $883,045 was provided to the Red Lake Band of Chippewa Indians to help the Tribe develop an integrated, coordinated behavioral health response to assist with the aftermath of the school shooting at Red Lake High School. The grant supports a comprehensive structure of services designed to establish a community-wide response to the trauma and loss experienced on March 21, 2005. SAMHSA also provided a $300,000 1-year SERG to the Standing Rock Sioux Tribe to provide outreach services and resource coordination to at-risk youth/young adults (substance abuse and/or mental health) and to those families and Tribal members affected by the suicides among youth and young adults on the reservation.

Suicide Prevention: In addition to the SERG issued to Standing Rock, SAMHSA also awarded $400,000 to the Native American Rehabilitation Association to combat youth suicide among Oregon's nine Federally recognized Tribes. The program is designed to link traditional spiritual and cultural beliefs with the best known practices in youth suicide prevention.

Mental Health Infrastructure: Under the Circles of Care program, SAMHSA awarded a total of $2,400,000 million in three-year grants to seven Native organizations, along with $600,000 conveyed in Inter-Agency Agreements to IHS and the National Institute of Mental Health (NIMH) for technical assistance on infrastructure development and participatory evaluation. The grantees include Sinte Gleska University, South Dakota; Cook Inlet Tribal Council, Alaska; Quilete Tribe, Washington; Muscogee (Creek) Nation, Oklahoma; Denver Indian Family Resource Center, Colorado; Indian Health Care Resource Center of Tulsa, Inc., Oklahoma; and Native American Rehabilitation Association of Portland, Oregon. The communities will develop plans to transform their behavioral health service and support systems for their children, youth, and families.

Substance Abuse Prevention and Treatment: Under the Drug-Free Communities Support program, SAMHSA awarded $682,443 to several Tribal entities to aid in the prevention of substance abuse. The grantees include the Yakutat Tlingit Tribe of Alaska, Menominee Indian Tribe of Wisconsin, Mississippi Band of Choctaw Indians, Osage Tribe of Indians of Oklahoma, Salish Kootenai College of Montana, and the Great Lakes InterTribal Council, Inc. The grantees will reduce substance abuse among youth and, over time, among adults by addressing the factors that increase the risk of substance abuse, while promoting the factors that minimize the risk of substance abuse. The grantees will also establish and strengthen community anti-drug coalitions.

SAMHSA awarded $100,000 to the National Indian Youth Leadership Project from Gallup, New Mexico, to develop the curriculum for the Walking in Beauty Program, a successful three-year substance abuse prevention program. This program is based on a positive, youth development approach to prevention. Specifically, it is designed to implement a strategically designed set of adapted interventions aimed at reducing risk factors and enhancing protective factors related to substance use and high risk behaviors in a target population of adolescent Native American (primarily Navajo) and other young women.

Under the Targeted Capacity Expansion Grants (TCE), SAMHSA awarded $500,000 per year for three years to the Montana Adult Methamphetamine Treatment Coalition. The largest racial/ethnic minority population expected to be served by this Coalition is the Native American population. SAMHSA also awarded a TCE Grant of $500,000 per year for three years to the Mendocino County Department of Public Health in California. The Mendocino County Department of Public Health will provide services to methamphetamine users and family members, 10 percent of whom are expected to be Native American.

SAMHSA awarded $3,718,115 in TCE discretionary grants to eight AI/AN applicants. The TCE grant program is designed to meet the disproportionate substance abuse treatment needs of certain Native communities; expand or enhance the community's ability to provide a comprehensive, integrated, and community-based response to a targeted, well-documented substance abuse treatment capacity problem; improve the quality and intensity of services; and encourage the substance abuse treatment system to be more responsive and bridge the gap between what is needed by native populations and what is known about effective treatments. For example, SAMHSA awarded $500,000 to the Native American Health Center to expand residential substance abuse treatment services and meet the needs of addicted NA men.

HIV/AIDS: SAMHSA awarded $254,320 to The Native American Health Center in Oakland, CA, and $254,320 to the Friends Research Institute in Baltimore, MD, to provide substance abuse prevention and HIV and Hepatitis prevention services to urban Indian populations.

Homelessness: SAMHSA awarded $399,630 per year for five years to the Rural Alaska Community Action Program to provide substance abuse and mental health services to the homeless, many of whom are Alaska Natives. The Cook Inlet Tribal Council, which serves Native Alaskans, received $400,000 to reduce substance abuse and homelessness. This will be done by initiating transitions into long term recovery, expanding existing treatment capacity, improving mental and physical health, improving criminal justice status and enhancements in education, employment and income. The Presbyterian Medical Services in Santa Fe, NM, was also awarded $399,956 per year for five years to strengthen alcohol treatment services for homeless people with alcoholism who are predominately Navajo.

Activity 3: Assistance to Tribal Entities Following Tribal Visits and Meetings

As a result of visits to Region VIII Tribes during the FY04 regional Tribal consultation meetings, former Deputy Secretary Claude Allen requested that SAMHSA provide technical assistance to two Tribes in particular – the Northern Cheyenne Tribe of Montana and the Crow Tribe of Montana – to address the spread of methamphetamine use and the problem of methamphetamine labs. Direct SAMHSA communications with the two Tribes began in October 2004.

For the Northern Cheyenne, SAMHSA staff offered to review a proposal for methamphetamine-related funding that the Tribe had submitted to IHS, for which they had not yet received feedback. SAMHSA provided detailed comments on the proposal to the Tribe's Health Director.

For the Crow Tribe, SAMHSA requested that its National AI/AN Resource Center, One Sky, visit the reservation and its Seven Hills Healing Center. The site visit, which entailed extensive discussions with the Tribal Chairman and program staff, resulted in One Sky providing recommendations on how to improve the Healing Center's structure, fiscal management, record keeping procedures, program quality, and outcome measurement and management. In September, the Crow Tribal Chairman convened a Summit on Drugs and Alcohol, the purpose of which was to enlist the help of Federal, State, and local agencies and healthcare providers to address the high incidence of methamphetamine use, dependence, and addiction on the Crow Reservation. CSAT staff and the Director of One Sky participated in the summit. The meeting concluded with the development of action steps to address a number of important issues. CSAT provided resource materials on methamphetamine use, treatment options, how to get the community involved, and local contacts at the Drug Enforcement Agency to provide further assistance.

In June, SAMHSA's CSAT Director and the Director of the Office of Policy, Planning and Budget in the Agency's Office of the Administrator, met in San Diego, California with the head of the Navajo Nation's Department of Behavioral Health Services and members of his staff. During the meeting, the Navajo Nation presented their proposal for the Shiprock Adult Residential Treatment Center. CSAT's Director indicated willingness to provide technical assistance to develop a strategic plan for this proposal and identify potential funding streams for the different phases of the project. Subsequently, on September 30, the Navajo Nation broke ground for the new treatment facility; CSAT staff attended the ceremony.

In August, Deputy Secretary Alex Azar made site visits to a number of Alaska Native communities. Subsequently, he requested that SAMHSA and IHS develop a joint plan to address the high rates of suicide in two remote communities – Savoonga and Gambell. SAMHSA and IHS staff collaborated on the development of a draft plan which was submitted to Mr. Azar on October 17, 2005.

Expected Outcome(s): The primary outcome will be an increase in the numbers of Tribes and Tribal organizations receiving SAMHSA grants and services. Regarding specific funding that is provided to Tribal communities through the Agency's competitive grant awards, GPRA data are collected which will demonstrate to what degree there are significant returns on funds invested. In addition, SAMHSA's National Outcome Measures (NOMs) measure the outcome of programs and services provided.

Priority 2: Recruitment and Retention of Care Providers

Objective: To support programs and educational efforts that encourage the development of a cadre of professional racial/ethnic minority service providers who understand and competently address the needs of AI/ANs in the fields of substance abuse and mental health services.

Background: One of SAMHSA's cross-cutting principles for managing programs and initiatives is a focus on cultural competency and elimination of disparities in the incidence of mental illness and substance abuse. The Minority Fellowship Program (MFP) is an ongoing and long-term effort to recruit and facilitate the entry of racial/ethnic minority students, including American Indians and Alaska Natives, into mental health and substance abuse related careers appropriate care providers. In addition, SAMHSA's Addiction Technology Transfer Centers were designed to facilitate workforce development.

Activities: The MFP is a key activity in relation to recruiting and retaining care providers. In FY05, the CMHS Tribal-specific Circles of Care grant program, included Tribal colleges and universities as eligible entities for the first time. One of the grants went to Sinte Gleska University in South Dakota. CMHS also continues to facilitate the incorporation of traditional healers in Circles of Care projects as well as the Child Mental Health Initiative. CSAT, with its TCE grants, continues to support traditional Native healing practices. Finally, SAMHSA continues to participate in the American University program, Washington Internships for Native Students (WINS), which provides work experiences for AI/AN students in a variety of fields, including mental health and substance abuse. This has provided richly rewarding experiences for both the students and the SAMHSA workforce.

Expected Outcome(s): The above activities are expected to contribute to increasing the pool of culturally competent care providers in the fields of mental health and substance abuse.

Section 2

Overview of Consultation Activities

SECTION 2: OVERVIEW OF CONSULTATION ACTIVITIES

This section lists the consultation efforts that have been undertaken by HHS Regional Offices and Divisions during the last year. In addition to the regional Tribal consultations and the HHS Annual Tribal Budget Consultation Session, many other HHS consultations with Tribes occurred. In order to distinguish national from local or regional consultation efforts, this section is organized according to type of consultation, including: regional Tribal consultation sessions; HHS Annual Tribal Budget Consultation Session; HHS leadership visits to Indian Country; Intradepartmental Council on Native American Affairs (ICNAA); Red Lake response; Medicare Modernization Act; workgroups and task forces; Tribal delegation meetings; region- and division-specific consultation; and Tribal conferences and summits.

REGIONAL TRIBAL CONSULTATION SESSIONS

Since 2002, HHS Regional Directors have conducted annual regional Tribal consultation sessions with the Tribes in their region. These sessions were done in an effort to increase mutual awareness of both Tribes and HHS staff of issues and programs of concern. Conducting consultation on a regular basis in a closer proximity to Tribal communities provides the opportunity for an ongoing dialogue about Tribal concerns and priorities as well as the opportunity for HHS to provide feedback to Tribes on how their concerns and priorities are being addressed.

A long-term goal of HHS is to assist Tribes in fully accessing the resources of those HHS programs for which they are eligible. To accomplish that goal requires Tribes to have a better understanding of HHS programs. These regional consultation sessions provide one regular opportunity to foster that enhanced level of understanding. Because of the complexity and breadth of HHS programs, as well as spectrum of Tribal issues, these regional sessions are critical to the overall consultation effort at HHS.

Conversely, for HHS to help address the needs of Tribal communities requires that decision makers, as well as the staff, develop a thorough understanding of the priorities of Tribes, the effects of Federal actions on Tribal communities, the underlying conditions that affect the health and human services concerns of Tribes, and the issues Tribes confront when interacting with HHS. This process of enhanced mutual understanding requires a long-term commitment from both HHS and Tribes to reach out and learn.

The 2005 sessions conducted provided an ongoing opportunity for Tribes to provide HHS with their current priorities. The nine[1] sessions were conducted between March and June 2005. The sessions were attended by 894 total participants – 405 representatives of 145 Tribes, as well as Federal and state agency representatives.

These variations in the approach to the structure of the regional sessions were attempts to identify approaches that were most conducive to broad participation by the Tribes in each region and ultimately in recognition of the differences in circumstances that affect the many Tribes. Lessons learned from the variety of approaches taken in 2005 will assist in strengthening the regional sessions in 2006.

IGA Tribal affairs staff coordinated and provided technical assistance to the HHS Regional Offices as they planned and conducted their 2004 regional consultation sessions. IGA Tribal affairs staff made presentations and responded to questions at each of the sessions conducted by the regions. The session provides the Tribes the opportunity to make recommendations on the FY07 HHS budget request, in addition, the opportunity to updates the priorities raised during the 2004 sessions. Senior HHS leadership and representatives also attended the sessions from HHS Divisions.

[1] There are ten HHS regions, but there are no Federally recognized Tribes in Region III.

Region	Date	Tribal Representation	Federal and State Representation
Region I	5/19/05	**Tribal Representation:** • Aroostook Band of MicMac • Eastern Pequots • Houlton Band of Maliseet • Mashantucket Pequot Tribal Nation • Mohegan Tribe • Narragansett Tribe • North American Indian Center of Boston • Passamaquoddy Tribe at Indian Township • Passamaquoddy Tribe at Pleasant Point • Penobscot Indian Nation • United South and Eastern Tribes • Wampanoag Tribe at Acquinnah	**Federal Representation:** • HHS divisional and regional staff **State Representation:** • Massachusetts Medicaid • Maine Department of Public Health
Region II	5/12/05	**Tribal Representation:** • Oneida • Seneca • St. Regis Mohawk	**Federal Representation:** • HHS divisional and regional staff • Department of Agriculture • Department of Veterans Affairs • Social Security Administration **State Representation:** • Office of the Governor • New York Department of Health • New York Office of Children and Family Services • New York Office for the Aging • New York Office of Temporary and Disability Assistance
Region IV	4/18/05 – 4/19/05	• Eastern Band of Cherokee Indians • Miccosukee Tribe of Indians of Florida • Mississippi Band of Choctaw Indians • Poarch Band of Creek Indians • Seminole Tribe of Florida	**Federal Representation:** • HHS divisional and regional staff **State Representation:** • Alabama Department of Public Health • Florida Department of Public Health • Florida Department of Children and Families • Mississippi Office of the Governor • Mississippi Division of Medicaid • Mississippi Department of Health • Mississippi Department of Human Services • North Carolina Department of Health and Human Services • South Carolina Department of Social Services • South Carolina Department of Health and Environmental Control

Region	Date	Tribal Representation	Federal and State Representation
Region V	3/9/05 – 3/10/05	• Fon du Lac Reservation • Fon du Lac Band of Lake Superior Chippewa • Forest County Potawatomi • Gerald L Ignace Indian Center • Grand Traverse Band of Ottawa & Chippewa Indians • Great Lakes Inter-Tribal Council • Hannahville Indian Community • Ho-Chunk Nation • Huron Potawatomi • Lac Vieux Desert Health Center • Little River Band of Ottawa Indians • Leech Lake Band of Ojibwe • Little Traverse Bay Band of Ottawa Indians • Match-E-Be-Nash-She-Wish Potawatomi • Midwest Alliance of Sovereign Tribes • Mille Lacs Band of Ojibwe • Minnesota Chippewa Tribe • Oneida Tribe • Pokagon Band of Potawatomi Indians • Sault Ste. Marie Tribal Health • St. Croix Tribal Council • Stockbridge Munsee • United AmerIndian Center • Upper Sioux Community • White Earth Health Center	**Federal Representation:** • HHS divisional and regional staff **State Representation:** • Michigan Department of Community Health • Michigan Family Independence Agency • Michigan Office of Public Health Preparedness • Minnesota Tribal Relations • Minnesota Department of Human Services • Minnesota Tribal Health Care • Minnesota Department of Health • Minnesota Office of Emergency Preparedness • Wisconsin Department of Workforce Development • Wisconsin Tribal Affairs • Wisconsin Public Health Preparedness • Wisconsin Department of Health and Family Services
Region VI	4/6/05 – 4/7/05	• Absentee Shawnee • Alamo Navajo School Board, Inc. • All Indian pueblo Council • C-A Tribes of Oklahoma • Canancito Band of Navajos • Cherokee Nation • Chickasaw Nation • Chickasaw Nation Health System • Choctaw Nation • Choctaw Nation Health Services Authority • Choctaw Nation of Oklahoma • Citizen Potawatomi Nation Health Services • Iowa Tribe of Oklahoma • Isleta Pueblo • Jemez Pueblo • Jena Band of Choctaw Indians • Kaw Nation • Muskogee (Creek) Nation • Navajo Division of Health • Navajo Nation • Navajo Nation Department of Behavioral Health Services	**Federal Representation:** • HHS divisional and regional staff **State Representation:** • New Mexico Human Services Department • Oklahoma State Department of Health • Texas Department of State Health Services

Region	Date	Tribal Representation	Federal and State Representation
Region VI (continued)	4/6/05 – 4/7/05	• Navajo Nation - NAAA • Osage Nation • Pawnee Nation of Oklahoma • Ponca Tribe of Oklahoma • Pueblo of Acoma • Pueblo of Isleta • Pueblo of Laguna • Pueblo of San Felipe • San Felipe Family Services • Santa Clara Pueblo • The Chickasaw Nation • United South & Eastern Tribes, Inc. • Ysleta Del Sun Pueblo. • Bearskin Healthcare & Wellness Center • Clinton Indian Hospital • Crownpoint Healthcare Facility - Navajo • Hastings Indian Medical Center • Lawton Indian Hospital • LifeMasters • National Indian Childcare Association • Northeastern Tribal Health System • Oklahoma City Area Inter-Tribal Health Board • TrailBlazer Health	See previous page.
Region VII	4/7/05 – 4/8/05	• Iowa Tribe of Kansas and Nebraska • Kickapoo Tribe in Kansas • Omaha Tribe of Nebraska • Ponca Tribe of Nebraska • Prairie Band Potawatomi Nation • Sac & Fox Nation of Missouri • Santee Sioux Nation • Winnebago Tribe of Nebraska	**Federal Representation:** • HHS divisional and regional staff • Department of Veterans Affairs • Environmental Protection Agency **State Representation:** • Haskell University Indian Health Center • Kansas Office of Minority Health • Nebraska Department of Health and Human Services • Oklahoma Area Inter-Tribal Health Board • University of Kansas
Region VIII	6/8/05 – 6/9/05	• Blackfeet Tribe • Chippewa Cree Tribe • Eastern Shoshone Tribe • Navajo Nation • Northern Arapaho Tribe • Oglala Sioux Tribe • Paiute Tribe of Utah • Rosebud Sioux Tribe • Sisseton-Wahpeton Sioux Tribe • Southern Ute Tribe • Standing Rock Sioux Tribe • Turtle Mountain Band of Chippewa • Ute Mountain Ute Tribe • Yankton Sioux Tribe	**Federal Representation:** • HHS divisional and regional staff • Civil Rights Commission • Department of Education • Department of Housing and Urban Development • Department of the Interior, Bureau of Indian Affairs • Department of Labor • Environmental Protection Agency • General Services Administration • Small Business Administration

Region	Date	Tribal Representation	Federal and State Representation
Region VIII (continued)	6/8/05 – 6/9/05	See previous page.	**State Representation:** • Colorado Commission on Indian Affairs • Colorado Department of Public Health and Environment • Montana Department of Health and Human Services • North Dakota Department of Health • South Dakota Department of Health • South Dakota Department of Human Services • South Dakota Department of Social Services • Utah Department of Health • Wyoming Department of Family Services
Region IX	5/23/05 – 5/24/05	• AK-CHIN Indian Community • Bear River Band of Rohnerville Rancheria • Big Sandy Rancheria • Cloverdale Rancheria • CTTP Robinson Rancheria • Fallon Paiute-Shoshone Tribe • Fort Mojave Indian Tribe • Hoopa Valley Tribe • Hopi Tribe • Jamul Indian Village • Moapa Tribe • Mooretown Rancheria • Navajo Nation • North Fork Rancheria • Pascua Yaqui Tribe • Pit River Tribe • Reno-Sparks Indian Colony • Rincon Band of Mission Indians • Salt River Pima-Maricopa Indian Community • San Carlos Apache Tribe • Susanville Indian Rancheria • Tohono O'Odham Nation • Walker River Paiute Tribe • Washoe Tribe • White Mountain Apache Tribe	**Federal Representation:** • HHS divisional and regional staff • Social Security Administration **State Representation:** • Arizona Department of Economic Security • Arizona Department of Health Services • Arizona Health Care Cost Containment System • California Department of Social Services • Nevada Department of Human Resources
Region X	5/25/05 – 5/26/05	• Alaska Native Health Board • Northwest Portland Area Indian Health Board • National Indian Health Board • Alaska Native Tribal Health Consortium • Aleutian Pribilof Islands Association • Chehalis Tribe • Chugachmiut • Coeur d'Alene Tribe • Colville Tribes • Confederated Tribes of Grand Ronde	**Federal Representation:** • HHS divisional and regional staff • Department of Veterans Affairs **State Representation:** • Oregon Department of Human Services • Washington Department of Social and Health Services • Washington State Health Care Authority

Region	Date	Tribal Representation	Federal and State Representation
Region X (continued)	5/25/05 – 5/26/05	• Confederated Tribes of Siletz Indians • Confederated Tribes of Umatilla • Confederated Tribes of Warm Springs • Coquille Tribe • Cowlitz Tribe • Jamestown S'Klallam Tribe • Lower Elwha Klallam Tribe • Lummi Nation • Makah Tribe • Nisqually Indian Tribe • Norton Sound Health Corporation • Orutsararmiut Native Council • Port Game S'Klallam Tribe • Puyallup Tribal Health Authority • Quileute Tribe • Quinault Nation • Samish Tribe • Shoalwater Bay Tribe • Skokomish Tribe • Squaxin Island • Spokane Tribe • Stillaguamish • Suquamish Tribe • Tulalip Tribes • Upper Skagit • Yakama Nation • Yukon Kuskokwim Health Corporation • National Congress of American Indians	**Other Representation:** • American Public Health Service Association • Benewah Medical Center • Manillaq Association • Turtle Island Institute • Yellowhawk Tribal Health Center

HHS ANNUAL TRIBAL BUDGET CONSULTATION SESSION

IGA is responsible for facilitating the HHS Annual Tribal Budget Consultation Session in conjunction with the Office of the Assistant Secretary for Budget, Technology, and Finance (ASBTF), ICNAA and its liaisons. HHS hosted the seventh Annual Tribal Budget Consultation Session on May 17 to 18, 2005. Alex Azar, Deputy Secretary, and Kerry Weems, Deputy Chief of Staff, provided opening remarks. Moderators of the formal consultation session included Regina Schofield, former Director, Office of Intergovernmental Affairs, Kerry Weems, Deputy Chief of Staff, Don Kashevaroff, President, Seldovia Village Tribe, and H. Sally Smith, Chairman, National Indian Health Board, and ICNAA Chair, Vivian Juan-Saunders, Tohono O'odham Nation. Also leading the HHS discussion was ICNAA Vice-Chair, Dr. Charles W. Grim, Director, Indian Health Service. Senior staff attended the session throughout the day and a half session.

Tribal representation included National Congress of American Indians, National Indian Child Care Association, National Indian Child Welfare Association, National Indian Council on Aging, National Indian Health Board, United South and Eastern Tribes, and 19 individual Tribal Leaders/Representatives. Tribal leaders presented formal testimony and attended sessions with HHS divisions to discuss policy and budget matters impacting their local communities. Tribes raised and proposed strategies to resolve issues within the broader categories of budget, consultation, legislation, regulation, research, and HHS programs and policy. More specifically, concerns were mentioned regarding small budget increase in comparison to CMS and inflation; key pieces of legislation; developing a research agenda for Indian Country that is inclusive of Indian researchers and implemented in the communities; relationships between states and Tribes; technical assistance to Tribes; and HHS grant policies and mechanisms, i.e. direct funding to Tribes instead of states and longer grant terms to reflect long-term strategies.

One key area of interest throughout the consultation was improving health care and health disparities. Topics of discussion included chronic disease prevention and management; health promotion; addressing diseases and health issues, such as hepatitis C, alcoholic liver disease, diabetes, hypertension, stroke, HIV/AIDS, STDs, tuberculosis; injury prevention and control, substance and tobacco abuse, nutrition, physical activity, obesity, high suicide rate, cardiovascular disease, and oral health care; health disparities; under-enrollment of Native Americans in Medicare and Medicaid. Other topics of focus included TANF; Head Start; child care; child welfare and protective services; children's mental health and suicide; elder social services; environmental issues; and emergency preparedness.

Responses to Tribal perspectives were made by HHS senior staff, including Dr. Craig Vanderwagon, Chief Medical Officer, IHS; Dr. Christina Beato, former Acting Assistant Secretary for Health; Bill Belton, Deputy Assistant Secretary for Budget; Kathleen Kendrick, Chief Operating Officer, AHRQ; Charles Curie, Administrator, SAMHSA; Kathleen Harrington, Director, Office of External Affairs; Sheila Cooper, Director, Program Operations, Administration for Native Americans, ACF; Leslie Norwalk, Deputy Administrator, CMS; Ralph Bryan, Senior Tribal Liaison, Office of Minority Health, CDC; Daniel Schneider, Deputy Assistant Secretary, ACF; Shannon Christian, Associate Commissioner, Child Care Bureau, ACF; Susan Orr, Associate Commissioner, Children's Bureau, ACF; Amanda Bryant, Head Start Bureau, ACF; Joe Bock and Paul Kirisitz, Division of Program Implementation, Children's Bureau, ACF; Grant Collins, Office of Family Assistance, ACF; Yvonne Jackson, Director, Office for American Indian, Alaska Native, and Native Hawaiian Programs, AoA; Bill Robinson, Director, Office of Minority Health and Health Disparities, and Chief Medical Officer, HRSA; Dr. Walter Williams, Director, Office of Minority Health, CDC; and John Ruffin, Director, National Center on Minority Health and Health Disparities, NIH.

HHS LEADERSHIP VISITS TO INDIAN COUNTRY

HHS senior staff has been visiting Indian Country regularly for more than five years. In 2005, HHS senior staff continued this tradition. This travel has been at the invitation of Tribal leaders who have repeatedly stated that there is no substitute for seeing health and human service conditions first hand in Indian communities.

On **October 18, 2004**, former Deputy Secretary Claude Allen visited the Indian Health Service's Phoenix Area Office in Phoenix, Arizona. Mr. Allen announced and awarded grant funding to eight Native American Tribes and health organizations throughout Arizona for their programs' efforts regarding Diabetes.

On **December 13 to 15, 2004**, former Deputy Secretary Claude Allen visited Alabama and Mississippi. Mr. Allen and HHS staff first met with the Tribal Chief of the Mississippi Band of Choctaw Indians, Chief Phillip Martin, in Philadelphia, Mississippi; their visit included tours of several Choctaw facilities, such as their Head Start, Early Head Start, and elderly activity centers. Next, HHS staff conducted a visit to the Poarch Band of Creek Indians in Atmore, Alabama. Vice Chairman Buford Roland and other Tribal staff conducted a tour of the Tribe's programs. This trip's activities included visiting the Tribal Clinic/Women Infant and Children Program and Optical Shop, as well as surveying hurricane damage, housing and utilities, and emergency response equipment. A meeting with Tribal and local and state officials to discuss lessons learned from the response to Hurricane Ivan was also held. Other HHS Officials accompanying Mr. Allen included Amanda Robinson, Executive Officer, Region IV; Richie Grinnell, Acting Nashville IHS Area Director; Garth Graham, Acting Deputy Assistant Secretary for Minority Health; Melissa Sanders, Branch Chief, Bioterrorism Hospital Preparedness Program, HRSA; Teresa Brown-Jesus, Program Analyst, Office of Public Health Emergency Preparedness; and Gena Tyner-Dawson and Dr. Eric Broderick, IGA Tribal Affairs Staff. Tim Martin, executive director of the United South and Eastern Tribes was also on the trip.

On **April 4 to 6, 2005**, Regina Schofield, former Director of the Office of Intergovernmental Affairs, conducted a trip to Oklahoma and Texas. HHS staff met with Choctaw Nation Chief Gregory E. Pyle and Executive Director of Operations and Management Mickey Peercy. Their tour of the Choctaw Nation Complex in Durant, Oklahoma, included visits to the Head Start, Childcare and Child Welfare Programs, Choctaw/Chickasaw Clinic, and Choctaw Nation Wellness Center. They also received a briefing by social services staff on efforts to reduce the incidence of child abuse. Ms. Schofield also attended the Region VI Tribal Consultation Session in Dallas, Texas, as part of this trip. HHS staff accompanying Ms. Schofield included Andrew Fredrickson, Associate Regional Administrator, Division of Medicaid and Children's Health, CMS; Dr. Ralph Bryan, Senior Tribal Liaison for Science and Public Health, CDC; James Randolph Farris, M.D., Regional Administrator, CMS; Ray Bishop, Director, Office of State and Tribal Programs, ACF; Floristene Johnson, AoA; Yvette C. Fryar, Office of Minority Health and Health Disparities, HRSA; Linda Penn, Regional Director, Region VI; and James Toya, IHS Albuquerque Area; John Daugherty, Jr., IHS Oklahoma City Area; and IGA Tribal Affairs Staff Gena Tyner-Dawson, Dr. Eric Broderick, and Stacey Ecoffey.

On May 24 to 27, 2005, Charles Curie, Administrator, and Andy Knapp, former Deputy Administrator, Substance Abuse and Mental Health Services Administration, and Bob McSwain, Deputy Director, Indian Health Service, visited the State of Washington, along with IGA Tribal Affairs Staff, HHS Region X Staff, and IHS Portland area staff. The trip included visits to the Quinault Nation in Taholah, Washington; the Lummi Nation in Bellingham, Washington; and the Region X Consultation in Ocean Shores, Washington. HHS staff accompanying Mr. Curie included Steve Henigson, Acting Regional Director, Region X; Bob McSwain, IHS headquarters; Chris Mandregan, IHS Alaska Area; Doni Wilder, IHS

Portland Area; James Ivery, IGA; and IGA Tribal Affairs Staff Gena Tyner-Dawson, Dr. Eric Broderick, and Stacey Ecoffey.

On **July 31 to August 2, 2005**, Deputy Secretary Azar visited the State of Alaska. He was accompanied by Charles Curie, Administrator, Substance Abuse and Mental Health Services Administration; Michael O'Grady, former Assistant Secretary for Planning and Evaluation; Wade Horn, Assistant Secretary for Children and Families; Laura Ott, Deputy Assistant Secretary for Legislation (Human Services); James Whitfield, Regional Director, Region X; Bob McSwain, Deputy Director, IHS; Chris Mandregan, Alaska Area Director, IHS; and IGA Tribal Affairs staff Gena Tyner-Dawson, Dr. Eric Broderick, and Stacey Ecoffey. He was also accompanied during a portion of the trip by policy staff for Senator Murkowski, Senator Stevens, Congressman Young, and Governor Murkowski. The Deputy Secretary visited Anchorage, Eklutna, Nome, Savoonga, Gambell, Kotzebue, Shungnak and Fairbanks, touring HHS programs and services, and meeting with state officials and local community members throughout the week. In addition, he held a joint press conference with Senator Ted Stevens and met with officials from the University of Alaska at Fairbanks.

INTRADEPARTMENTAL COUNCIL ON NATIVE AMERICAN AFFAIRS (ICNAA)

During 2005, the ICNAA met on April 21 and December 1. The Council membership includes the heads of each HHS Division and serves as the Secretary's principal advisory body on Tribal health policy matters. The Council is chaired by Quanah Stamps, Commissioner of the Administration for Native Americans. The Vice-Chair is Dr. Charles Grim, Director of the Indian Health Service. The April meeting was facilitated by Regina Schofield, former Director of the Office of Intergovernmental Affairs (IGA) and opened by Deputy Secretary Alex Azar and Rich McKeown, Chief of Staff. The April meeting topics included health promotion and disease prevention; Native American health disparities; health information technology; increasing Tribal access to HHS programs; increasing awareness and effectiveness of human services with Native Populations; Medicare and Medicaid updates; Tribal Consultation Policy and regional sessions progress; and HHS Red Lake efforts.

The December meeting was facilitated by Jack Kalavritinos, Director of Intergovernmental Affairs, and opened by Kerry Weems, Deputy Chief of Staff. Topics discussed at the December meeting included HHS Council priorities; emergency preparedness; Hurricanes Katrina, Rita, and Wilma; pandemic flu preparedness and response; Native American Youth Initiative; increasing Tribal access to HHS programs; Medicare and Medicaid updates; Native American senior centers and other Administration on Aging efforts. IGA provides ongoing executive direction for the ICNAA. This is coupled with IGA's consultation responsibilities to receive the views of Indian Tribes and to ensure their inclusion in the policy development guided by ICNAA.

RED LAKE RESPONSE

On March 21, 2005 a tragedy struck the Red Lake Band of Chippewa Indians. The lives of ten members of the community were lost during a shooting. Many Federal departments responded to the community in this time of need. They included the Department of Health and Human Services, Department of Justice, Department of Interior, and Department of Education, as well as many state and other non-governmental organizations. The descriptions below highlight the contributions of HHS Divisions.

Administration for Children and Families (ACF), Administration for Native Americans (ANA)

On March 29, ANA Commissioner Stamps attended the funerals at the Chippewa Band of Red Lake Indians. She also met with Tribal Representatives to determine the needs in response to the tragic community events.

Commissioned Corps Office of Force Readiness and Deployment (OFRD)

In response to community needs, the OFRD deployed health care workers and mental health providers to the Red Lake community to assist the Tribe and the IHS Hospital staff in addressing the many needs in the community following the shooting.

Health Resources and Services Administration (HRSA)

HRSA collected and presented regional health resource data for the crisis period that followed the tragic incident at Red Lake.

Intergovernmental Affairs (IGA), Tribal Affairs/ICNAA

IGA/Tribal Affairs, through the ICNAA, coordinated HHS activities to respond to the Red Lake Nation shooting and helped to determine each division's level of current services to respond to the needs of the Red Lake Nation. In addition, a member of the IGA Tribal staff was on detail to the Red Lake community for four weeks assisting in the Tribe in responding to the tragedy.

Indian Health Service (IHS)

The IHS Bemidji Area Director was the HHS point of contact and lead for this response. She worked extremely closely with the Tribe and the community as well as other Federal, state, local and non-governmental partners to respond to the needs of the community. In addition the IHS Director and Chief Medical Officer visited the community in the weeks following the event to offer their support.

Region V

The Region V Acting Regional Director worked with HHS staff, including the IHS Area Director and Region V Office of the Regional Health Administrator (ORHA), CMS (maximizing Medicare funding), HRSA, and FOH staff, to support Red Lake/coordinate internal resources to address the tragic school shootings. On March 27, the Acting Regional Director traveled to Bemidji, Minnesota for the week to provide ground support and assistance managing the command center ("Care Center") located in the Red Lake Hospital. The Acting Regional Director assisted the IHS Area Director, the Tribal-designated lead for the effort; and served as gubernatorial/state liaison, facilitating Federal-state collaboration by working with the gubernatorial-designated Minnesota State Red Lake Team (Public Safety, Health, Human Services and Education). On April 27, the Acting Regional Director returned to Red Lake, at the request of the Tribal health director, to attend a meeting with Red Lake and state representatives. To address urgent social services/child welfare needs, the Acting Regional Director later facilitated ORHA funding of social work interns and on-site technical assistance by the ACF child welfare specialist. An inter-agency agreement with IHS-Bemidji to address violence was developed by Region V OMH.

Substance Abuse and Mental Health Services Administration (SAMHSA)

In April, SAMHSA Center for Mental Health Services (CMHS) staff and the Director of the One Sky Center visited the Red Lake Band of Chippewa Indians. SAMHSA and One Sky collaborated closely with IHS personnel during the visits, providing support that included technical assistance related to building infrastructure and applying for SAMHSA Emergency Response Grants (SERGs). The Tribe has received SERG funding.

MEDICARE MODERNIZATION ACT

With the impending initiation of the Medicare Modernization Act (MMA) on January 1, 2006, HHS regions and divisions, including CMS, IGA, and IHS, prepared for its implementation in Indian Country throughout FY05. Numerous meetings, exhibits, presentations, and consultations were conducted with Tribes and Tribal audiences for the purposes of awareness, education, outreach, and training about the new Medicare Part D prescription drug coverage plan. Frequent topics of discussion included Medicare Part D's impact for Tribal beneficiaries; eligibility/enrollment; key issues for Indian Health programs; and key AI/AN outreach messages and products.

Date	Consultation	In Attendance	Summary
10/13/04	IHS/CMS Training: "Medicare Approved Drug Discount Card and the American Indian/Alaska Native Medicare Beneficiaries"	Kickapoo Nation, Prairie Band Potawatomi Nation, Iowa Tribe of Kansas and Nebraska, Muscogee Creek Nation, Cherokee Nation, Kaw Nation of Oklahoma; Oklahoma Area IHS, CMS Region VII and VI; Oklahoma City Area Inter-Tribal Health Board, Haskell Health Center, White Cloud Clinic, Lawton Indian Hospital, Kansas Department of Social and Rehabilitation Services, Computer Science Corporation, Pharmacy Care Alliance	Training for Tribal representatives in Oklahoma.
1/26/05	MMA Coordination Meeting	IGA Director, CMS Administrator, IHS Director	IGA Director convened meeting to discuss close coordination and implementation of MMA for AI/AN beneficiaries.
5/24/05	IHS/CMS Awareness Training: "Medicare Prescription Drug Coverage and the AI/AN Beneficiaries"	CMS; Oklahoma City Area IHS; Tribes from Oklahoma and Kansas; Region VII and VI, SSA; Oklahoma City Area Inter-Tribal Health Board, Haskell Health Center, Kansas Department of Social and Rehabilitation Services, Senior Health Insurance Counseling of Kansas (SHICK)	Awareness Trainings for Tribal representatives from Oklahoma and Kansas.
6/14/05	CMS/SSA Training: "Medicare Prescription Drug Benefit and the Low Income Subsidy"	Leaders, Health Directors and Health/Social Services Providers from the Kickapoo Nation, Iowa Tribe of Kansas and Nebraska, Sac & Fox Nation of Missouri; SSA, CMS Region VII; Senior Health Insurance Counseling of Kansas (SHICK)	CMS Region VII partnered with SSA to provide training to Kansas Tribes health and social services providers. SSA and CMS met with AI/AN Medicare beneficiaries one-on-one to answer questions related to the new benefit and in some cases assist them in applying for the low income subsidy.
6/16/05	Meeting with St. Regis Mohawk	St. Regis Mohawk, CMS Region II, SSA	CMS met with senior Tribal members and their representatives to discuss services and Part D implementation
6/27/05	CMS Open Door Forum on Indian Health and Medicare Part D	IGA/Tribal Affairs staff, CMS staff, IHS staff, SSA staff	CMS forum focused on raising awareness of MMA and provided an opportunity for interested individuals to discuss Tribal participation.

Date	Consultation	In Attendance	Summary
6/30/05	CMS Tribal Technical Advisory Group Meeting and Tribal Participation at Bus Tour Sites	IGA/Tribal Affairs staff, CMS staff, TTAG Chairwoman and members	CMS meeting focused on MMA implementation. IGA coordinated the tribal government, state and local partners.
9/1/05 – 9/2/05	All IHS Area Part D Lead Coordinators	CMS, IHS	Train the trainer session on Part D
7/6/05– 7/8/05	National Medicare Education Campaign	IGA/Tribal Affairs staff, CMS tribal staff, IHS staff, tribal representatives	CMS led a 3-day meeting focusing on the National Medicare Education Campaign. IGA worked to garner support of tribal leaders and tribal communities for this effort.
9/5/05	Part D Trainings for all IHS areas	CMS, IHS	Implementation training on Part D
2004 – 2005	Outreach to tribal communities in Region IX	Region IX Director's Office, Federal Regional Council Tribal Affairs Committee	Outreach for Medicare Part D, including a presentation for Bureau of Indian Affairs' Tribal Leaders Council.
2004 – 2005	Medicare Prescription Drug Coverage Awareness Trainings	CMS, IHS Area Staff, HHS Regional staff, SSA, State representatives, Tribal representatives	Awareness Trainings in the following areas: Mayetta, KS; Albuquerque, NM; Window Rock, AZ; Atlanta, GA; Catoosa, OK; Bernalillo, NM; Gallup, NM; Albuquerque, NM; Midwest City, OK; Nashville, TN; Anchorage, AK; Portland, OR; Seattle, WA; North Dakota, South Dakota, Nebraska and Iowa; and Michigan, Minnesota, and Wisconsin.
2004 – 2005	Outreach, Education, and Training	CMS, IHS, SSA, SHIP	CMS Division of Medicare Operations NAC and partners trained I/T/U professionals to assist tribal patients in their service area regarding Medicare Prescription Drug Coverage. Sessions were held in Las Vegas, NV; Phoenix, AZ; Tucson, AZ; Sacramento, CA; Gallup, NM; Minneapolis, MN; Redding, CA; and Sacramento, CA.
2004 – 2005	Outreach, Education, and Training presentations and exhibits at Tribal conferences	CMS, SSA, conference participants	7th Annual National IHS Partnership Conference, Scottsdale, AZ; 17th Annual Arizona Indian Council on Aging Conference, Tucson, AZ; 1st Annual Urban American Indian Disability and Vocational Rehabilitation Summit, Phoenix, AZ; Second Annual American Indian Nation 2004 Conference, Los Angeles, CA; Oklahoma Tribal Elders Conference, Oklahoma City, OK; Tribal Leader Health Summit, Bow, WA; Bi-Annual NPAIHB/CRIBH Conference of West Coast Tribes, Lincoln City, OR

WORKGROUPS AND TASK FORCES

When new or revised national policies affect an Indian Tribe or Tribes, HHS can establish workgroups or task forces to develop recommendations on technical, legal or policy issues. In 2005, HHS convened workgroups to address issues, such as Medicare, barriers to access, legislation, long-term care, health disparities, budget formulation, and consultation policies.

REGIONAL WORKGROUPS AND TASK FORCES

Sponsor	Workgroup	Membership	Summary
Region VI	Intra-Agency Tribal Issues Workgroup	ORD, ACF, AOA, CMS, HRSA, OCR, IHS Area Offices, RHA, Navajo Nation, Oklahoma Inter-Tribal health Board, United South & Eastern Tribes, Inc., other Tribal organizations	The mission is to increase communication among Region VI HHS agencies in order to educate one another about Tribal issues, to collaborate as "one department on Tribal projects and initiatives, and to identify Tribal services needs in order to better serve Native American people in Region VI." Activities included planning 2005 Regional Tribal Consultation Session.
Region VI	Regional Office CMS Tribal Workgroup	Individuals from the Survey and Certification, Medicaid, and Medicare Divisions of CMS	This workgroups was formed to meet the concerns and issues of Native American Tribes in the Dallas region.

DIVISION WORKGROUPS AND TASK FORCES

Sponsor	Workgroup	Membership	Summary
Administration for Children and Families, Administration for Native Americans	ACF Native American Affairs Workgroup	Management representatives from ACF Central Program Offices and Region X designee, Office of Child Support Enforcement. ANA is workgroup lead.	Workgroup has monthly discussions to address cross-cutting and program specific concerns involving Native Americans and improve services and communications with Tribes and Native Communities. Workgroups conducts ongoing consultation and collaboration among ACF program with Tribal initiatives and grant programs.
Administration for Children and Families, Child Care Bureau	Tribal Workgroup	CCB Staff; ACF Regional Staff; TWG members; CCB's contractor, the Tribal Child Care Technical Assistance Center (TriTAC)	The TWG meets several times a year via phone and in person to informally advise the CCB in developing policies and procedures and technical assistance for Tribal child care programs across the country.

Sponsor	Workgroup	Membership	Summary
Administration for Children and Families, Child Care Bureau	102-477 Workgroup	ACF staff: Child Care Development Fund and Division of Tribal TANF Management and, Office of Administration staff.; BIA-477 program and other BIA program staff; Tribal grantees; Department of Labor staff; Tribal Employment and Training Directors	The 102-477 Workgroup was established by Tribes to play a major role in the implementation and oversight of Public Law 102-477, the Indian Employment, Training, and Related Services Demonstration Act of 1992. This Workgroup works with Federal agency partners to monitor Federal agency participation in PL 102-477 and ensure that Federal agencies are coordinating with Tribes, pursuant to PL 102-477.
Administration for Children and Families, Head Start Bureau	Early Childhood Facilities Workgroup	Staff from Office of Commissioner for ACYF, Child Care Staff, Head Start Bureau Staff, IHS, Region VIII Staff	During the first and second quarters, this workgroup convened from Head Start and Child Care Bureaus. Discussion on what performance standards, regulations, and requirements affect Tribal early childhood facilities.
Agency for Healthcare Research and Quality (AHRQ)	Departmental workgroup to develop a Tribal advisory group on health research	Wendy Perry, AHRQ; staff from IHS, NIH, ASPE, IGA, OMH, CDC	The group met to develop the framework and understandings for the subject advisory group.
Administration on Aging (AoA)	Long-Term Care in Indian Country	Yvonne Jackson, AoA; Bruce Finke, IHS; Dorothy Dupree, CMS; and Sheila Cooper, ANA. Tribal representatives	Ongoing agency coordination resulted in the first AI/AN Long Term Care Conference, “Honoring Our Elders: Best Practices in Long Term Care.” Over 200 participants learned about promising practices and sustainable long-term care programs in Indian Country.
Assistant Secretary for Planning and Evaluation (ASPE)	Barriers Study Workgroup	Staff from ASPE, ASBTF, ANA, IGA, ACF, AoA, NIH, CDC, HRSA, SAMHSA, IHS, National Congress of American Indians, and the Tribal Self-Governance Advisory Committee	Meets periodically to advise HHS on all phases of the Barriers Study and review and comment on interim and final reports.
Agency for Toxic Substances and Disease Registry (ATSDR)	ATSDR Ad-Hoc Tribal Workgroup	Dean Seneca, Larry Cseh, Alan Crawford, Diane Dennis Stephens, Chris Wash, David Conrad, Ron Jamison, Tom Sinks, Harold Frank, Ken Jock, Earl Hatley, Robert Shimerck, Stephan Mangolis, Virgina Begay	The main topic of discussion was the development of an ATSDR Tribal Consultation Policy by receiving input from the Tribes on two primary issues: 1) components of the ATSDR Tribal Consultation Policy and 2) merging the ATSDR policy with the CDC policy into one that will serve the needs of both agencies.

Sponsor	Workgroup	Membership	Summary
Centers for Disease Control and Prevention (CDC)	Preparedness Workgroup	Coordinating Office of Terrorism Preparedness and Emergency Response (COTPER) and Network for Public Health Preparedness	This new workgroup has begun having regular meetings via conference calls to network with state and local public health agencies. An internal Preparedness Workgroup will provide educational and training resources to AI/AN Tribes and communities in support of their efforts to improve Tribal public health emergency and bioterrorism preparedness and response.
Centers for Medicare and Medicaid Services (CMS)	Tribal Technical Advisory Group (TTAG)	CMS Central and Regional Office Staff, IHS, TTAG	TTAG addresses implementation of Medicare Part D and also works on the integration of TTAG in all CMS Tribal issues, development of the CMS strategic plan, and action needed on Tribal issues currently pending in CMS. TTAG has 3 subcommittees on Education & Outreach; MAM; and Across State Borders.
Health Resources and Services Administration (HRSA) and Indian Health Service (IHS)	Health Professions Workgroup	HRSA/Bureau of Health Professions (BHPr) staff and IHS staff	The Workgroup reports that the NHSC currently has 65 clinicians working at I/T/U sites, an increase of 23 since May 2005. The number of loan repayors approved by the NHSC to work at IHS and I/T/U sites has also increased due to this collaboration from no loan repayors working in IHS and I/T/U sites in May 2005 to a preliminary count of 8 today. This increase in number of clinicians is directly related to the recruitment efforts of both the IHS staff and the NHSC.
Health Resources and Services Administration (HRSA) and Indian Health Service (IHS)	HIV/AIDS Workgroup	HRSA/HAB staff and IHS/ HIV/AIDS Program staff	HRSA and IHS signed a Collaboration Agreement to reduce health disparities in chronic and other diseases; increase the supply of health professionals available to provide health care in Indian Country and other underserved areas; and reduce the burden of HIV/AIDS in the Indian people and other populations. To implement the agreement, potential mechanisms for grantees and providers which service AI/ANs are being discussed as tools to communicate with and notify Tribal organizations, Tribal leaders, IHS, and urban Indian centers of CARE Act resources. In addition, the HIV/AIDS workgroup recently completed a technical assistance needs assessment of CARE Act grantees that provide services to AI/ANs. The assessment identified confidentiality, trust, stigma, coordination among agencies, transportation, socioeconomic status, cultural competency, and co-morbidities as barriers to providing HIV primary care and support services.

Sponsor	Workgroup	Membership	Summary
Health Resources and Services Administration (HRSA) and Indian Health Service (IHS)	Health Disparities Workgroup	HRSA/BPHC staff and IHS Program staff	This workgroup expanded access to quality primary and preventive health care and strengthened the operations of existing health centers and I/T/U program organizations. The workgroup began with the most immediate goal of expanding access by increasing the number and quality of applications for 330 funding from I/T/U organizations. A Frequently Asked Questions (FAQ) document, a form of technical assistance before and after the grantee is funded, was crafted and distributed along with a joint letter from both agency heads in August 2004 to all I/T/U organizations interested in 330 funding opportunities. Another area the workgroup focused on was sharing best practices in the area of Clinical Quality. HRSA and IHS collaborated on lessons learned from Electronic Health Record implementation as well as shared best practices from the nationally recognized work of the HRSA Health Disparities Collaborative, particularly those participating health centers caring for more than 20% of Native American populations having experienced decreases in health disparities.
Intergovernmental Affairs (IGA)	HHS Federal-Tribal-State Human Service workgroup	IGA/Tribal Affairs staff, NCAI staff, American Public Human Services Association staff	IGA/Tribal Affairs met with NCAI and APHSA to discuss the Human Service Collaboration Project, including planning a policy forum and the possibility of collaborating with a HHS conference or regional meetings.
Intergovernmental Affairs (IGA) and Indian Health Service (IHS)	Tribal Consultation Policy Revision Workgroup (TCPRW)	IGA/Tribal Affairs staff, Workgroup members; Tribal Leaders and Representatives from the 12 IHS Area Offices; IHS staff	The TCPRW met extensively throughout the year to accomplish the revision of the Secretary’s Tribal Consultation Policy which culminated with the signature of former Secretary Thompson on January 14, 2005 and transmitted by Secretary Leavitt to tribes on March 11, 2005.
Indian Health Service (IHS)	Direct Services Tribes (DST) Planning Committee	Tribal Leaders and representatives from the 9 IHS Areas serving Tribes that continue to receive care directly from IHS	The DST Planning Committee met quarterly to plan a national conference focusing issues of DST and to develop a charter creating a DST Tribal Advisory Committee to the Director, IHS
Indian Health Service (IHS)	Tribal Self-Governance Advisory Committee (TSGAC)	The TSGAC is comprised of 18 Tribal elected officials who serve as delegates and alternates.	The Committee met with the IHS Director and staff on a quarterly basis. Issues discussed by the TSGAC with IHS focused on the furtherance of self-governance in the IHS and issues such as diabetes allocation, consultation processes, etc.

Sponsor	Workgroup	Membership	Summary
Indian Health Service (IHS)	IHS Facilities Appropriation Advisory Board (FAAB)	12 Tribal members and two IHS staff	The FAAB advises the IHS Director on issues regarding facilities construction and maintenance; evaluates proposed changes to the Health Care Facilities Construction Priority System; and provides recommendations for modifications to the system.
Indian Health Service (IHS)	IHS/Tribal Contract Support Cost (CSC) Workgroup	Open to all Tribal leaders and representatives and IHS and Federal staff with an involvement or interest in the administration of CSC within IHS.	The Workgroup met twice during fiscal year 2005 to examine potential changes to current policy concerning the administration of CSC and how these costs are allocated to Tribes and Tribal organizations.
Indian Health Service (IHS)	Tribal Leaders Diabetes Committee (TLDC)	One elected Tribal leader from each of the 12 IHS Areas and 1 member-at-large	The TLDC met to continue to foster dialogue and partnership between Indian communities and the IHS.
Indian Health Service (IHS)	IHS National Budget Formulation Workgroup	Two Tribal representatives from each of the 12 IHS Areas	The Workgroup met twice during the year to assist the IHS in establishing priorities for the fiscal year 2007 budget and later to evaluate the session with the goal of implementing improvements for 2008.
Indian Health Service (IHS)	National "437" Steering Committee	One Tribal Leader representing each of the 12 IHS Area Offices	Numerous meetings and conference calls of the committee occurred in fiscal year 2005 in which advice on reauthorization of the Indian Health Care Improvement Act was provided to IHS and others.
Indian Health Service (IHS)	IHS Information Systems Advisory Committee	6 Tribal Leaders and representatives, 1 representative of an Urban Indian program, and 8 IHS staff from throughout IHS system.	The Committee met twice during 2005 and discussed issues such as the electronic health record, capital planning and investment, security issues, etc.
Indian Health Service (IHS)	Health Promotion/Disease Prevention Advisory Committee	11 Tribal Leaders and representatives; 9 IHS and Federal staff representatives.	The Committee met twice during 2005 to review the findings of the IHS Preventive Task Force and determine priorities, to identify partners both in the Federal and non-Federal arena, and promote findings through the IHS, Tribal and Urban systems.
Indian Health Service (IHS)	Injury Prevention Tribal Steering Committee	12 Tribal representatives from each of the IHS Area Offices	The Committee held monthly conference calls and met twice during 2005. The Committee provides advice and guidance to the IHS Injury Prevention Program and raises awareness of injury problems facing Indian people.

Sponsor	Workgroup	Membership	Summary
National Institutes of Health (NIH), Fogarty International Center (FIC)	Strategic Committee Planning for International Polar Year (IPY)	NIH Institute and Center representatives including FIC, NIMH, NIAID and NIEHS. Division representatives included SAMHSA and other agency representatives from the Smithsonian Institution.	In its role as NIH focal point for Arctic issues, FIC formed and convened a steering committee to strategize and plan for IPY, 2007–2008. FIC worked in the intergovernmental context to ensure that human health becomes part of the IPY agenda. Indigenous peoples' issues, particularly Alaska Natives, are among the four priority topics to be pursued by the U.S. team.
National Institutes of Health (NIH)	NIH American Indian Alaska Native (AI/AN) Group	Staff representatives from the Offices of Communications and Public Liaison (OCPL) at four components of the National Institutes of Health (NIH), including: National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), National Institute on Aging (NIA), National Institute of Child Health and Human Development (NICHD), and National Institute of Dental and Craniofacial Research (NIDCR).	In an effort to expand outreach to AI/AN communities, NIAMS established a workgroup that met a number of times from May to October to identify how to enhance outreach and health promotion with AI/AN communities. It determined that the first course of action was to understand the current efforts of the NIH. The group initiated a plan to hold a workshop, which was held on 11/1/05. The agenda for the workshop, "Taking Action: Health Promotion and Outreach with American Indians and Alaska Natives," addressed community analysis, health behavior, access to health care, and lessons learned from NIH health promotion programs. Representatives from AI/AN health organizations and the IHS, who are members of the Navajo Nation, Dakota Nation, Cherokee Nation, and Buckland Tribe were speakers. Workshop outcomes included a literature review and a report.

TRIBAL DELEGATION MEETINGS

During 2005, HHS continued an open door policy for Tribes and Tribal organizations. HHS senior leaders and program staff met at the request of Tribes to discuss issues of concern.

REGIONAL TRIBAL DELEGATION MEETINGS

Sponsor	Date	Tribe(s)	In Attendance	Summary
Region VI	10/8/04	Santa Clara Pueblo, Espanola	Regional Director Linda Penn	Presented $179,369 ACF grant through the Administration for Native Americans, which will enable the development of a Tribal Office of Vital Statistics. Ms. Penn also discussed the Medicare Prescription Drug Discount Card and sent MMA materials to the Pueblo.
Region VI	10/22/04	Cherokee Nation Health Services Group, Tahlequah, OK	Regional Director Linda Penn	Presented a Steps to a Healthier U.S. grant award. Chief Chad Smith, who accepted the award, expressed appreciation on behalf of the Cherokee Nation for the support of HHS in leveling the playing field for Tribes. In her remarks, Ms. Penn commended the Tribe for their ability to compete with states, cities, and other large entities to receive the grant. Following the presentation, Ms. Penn received a briefing on current activities of the Cherokee Nation and toured their facilities.
Region VI	4/19/05	Chickasaw Nation Health System, Ada, Oklahoma	Regional Director Linda Penn	Met with Bill Lance, Administrator, who attended the Region VI Tribal Consultation Session and brought up the idea/issue of partnerships and collaborations with private sector companies who could enhance service delivery in Tribal communities, specifically how private technological companies could enhance service delivery. The Chickasaw Nation has an aggressive agenda to increase the efficiency and quality of service delivery by maximizing the use of cutting edge information technology systems. Ms. Penn provided a packet of information on the President's and the Department's IT initiatives.
Region VI	4/20/05	Absentee Shawnee Tribe	Governor Ken Blanchard, Lt. Governor Kenneth Daugherty, and Tribal Secretary Marian Reeves, Regional Director Linda Penn	Regional Director Penn participated in a breakfast meeting with Carolyn Romberg, Health Director and Lesa Byford, Legislative/Health Policy Analyst to discuss the Tribe's issues and the day's agenda that included a briefing and a tour of the Senior Center by Cindy Carpenter, Director of the Tribe's Title VI program followed by a tour of a current Head Start center and a new facility. Additionally, she toured the family services office and was briefed by the staff which outlined their programs and identified

Sponsor	Date	Tribe(s)	In Attendance	Summary
Region VI (continued)	4/20/05	Absentee Shawnee Tribe		major issues. Ms. Penn also visited the ceremonial grounds of the Little Axe Band and the White Turkey Band. She toured the Little Axe Clinic and Resource Center and was briefed by each staff.
Region VI	4/21/05	Citizen Potawatomi Nation	Regional Director Linda Penn	Attended a breakfast meeting with staff from the Absentee Shawnee Tribe and the Citizen Potawatomi Nation, followed by a tour of the Nation's leadership facilities. Vice Chairman Linda Capps briefed Ms. Penn on the history of the Citizen Potawatomi Nation and their current activities. Vice Chairman Capps briefed the Regional Director on numerous issues facing the Tribe. Rhonda Butcher, Director of the Office of Self-Governance escorted Ms. Penn on an extensive tour of other facilities including a fitness center and a child care facility. The tour ended with a leadership luncheon and debriefing session where written position papers were presented to the Regional Director who committed to pursuing each issue and providing timely feedback.
Region VI	4/21/05	Sac & Fox Nation	Regional Director Linda Penn	Chief Rhodes, Vice President and Second Vice President met with Regional Director Linda Penn and discussed a variety of issues including concerns about: urban health care, lack of resources for smaller Tribes, insufficient funding to improve sanitary conditions and inadequate education for Tribal children. Chief Rhodes expressed an interest in serving on workgroups and committees to be able to advance the needs of small Tribes. Ms. Penn agreed to secure additional information as well as to pass the concerns on to appropriate department employees for further examination.
Region VI	4/21/05	Kickapoo Tribe	Regional Director Linda Penn	Toured the Kickapoo Tribal Health/Fitness Center and met with Ginger James, Associate Director of Clinical Services and Gina Evans, Nursing Director. The tour included a site visit to the Head Start program as well as to an after-school youth program.
Region VI and ATSDR	4/7/05	Pueblo of Laguna	Patrick Young, ATSDR Regional Representative	Governor Roland Johnson expressed concern over historical uranium milling operations and processing on the Laguna Pueblo and about increased cancer rates to a population base of approximately 700. In response, Mr. Young requested a brief history from Governor Johnson regarding the uranium operation, concerns of any ongoing exposures, and health concerns.

Sponsor	Date	Tribe(s)	In Attendance	Summary
Region VI and ACF	4/13/05	Choctaw Nation	ACF Tribal staff	ACF Tribal staff followed up regarding issues raised during the consultation session and visit by IGA staff. The Choctaw Nation is concerned about the high incidence of child abuse and is surveying all of its programs in an effort to improve services in the area to reduce the rate of abuse. ACF staff has researched the issue and has contacted the Choctaw staff to work with them on the effort.
Region VII	9/27/05	Kickapoo, Sac & Fox Nation of Missouri, and Iowa Tribe of Kansas	Regional Director	The Regional Director presented remarks at the Kickapoo ground-breaking ceremony for the new dental clinic. The Regional Director also spoke briefly about the new Medicare Prescription Drug Plan and its emphasis on prevention.
Region VIII	1/05	Northern Cheyenne, Lame Deer, MT	Regional Director	Met with new President of the Tribe
Region VIII	1/05	In-Care Network, Inc, Billings, MT	Regional Director	Visited a non-profit agency which provides various services to Indian youth and families.
Region VIII	1/05	Montana/ Wyoming Tribal Leaders Council, Billings, MT	Regional Director	Met with Director
Region VIII	2/05	Southern Ute	Regional Director	Met with new Chairman of Southern Ute and with council members in Ignacio, CO
Region VIII	2/05	Ute Mountain Ute, Towaoc, CO	Regional Director	Met with new Vice Chairman of the Tribe and Health Center Director
Region VIII	3/05	Northern Arapaho Tribe of the Wind River Reservation, WY	Regional Director	Met with new Chairman and Co-Chairman
Region VIII	3/05	Southern Ute, Denver, CO	Regional Director	Met with Chairman
Region VIII	3/05	Ute Mountain Ute, Denver, CO	Regional Director	Met with the Vice Chairman and Treasurer of the Ute Mountain Ute
Region VIII	3/05	Indian Alliance, Helena, MT	Regional Director	Visited non-profit agency, which provides services to urban Indians in the Helena area
Region IX	11/4/04	Native American Health Center, Oakland, CA	Regional Director, IHS Director and IHS California Area Director	Visited Center to get a briefing on their efforts to expand into a larger, new building nearby and the capital campaign supporting the expansion.
Region IX	4/22/05	Friendship House, San Francisco, CA	Regional Director and the Surgeon General	Toured the Friendship House American Indian Healing Center's new facility. The Regional Director spoke at the ribbon-cutting ceremony and highlighted HHS' financial commitment to partner with Native Americans on substance abuse prevention.
Region X	1/18/05 – 1/20/05	NW Portland Area Indian Health Board	Executive Officer on behalf of Regional Director	Quarterly Board Meeting

Sponsor	Date	Tribe(s)	In Attendance	Summary
Region X	5/25/05	Quinault Indian Reservation, near Taholah, WA	Acting Regional Director	Visit to the Reservation
Region X	7/19/05	Aleutian Pribilof Islands Association	Regional Director, ACF Regional Administrator, Dimitri Philemonof, President and CEO	Discussed health and human service issues and planning for Acting Deputy Secretary's trip to Alaska.

DIVISION TRIBAL DELEGATION MEETINGS

Administration for Children and Families

Date	Sponsor	Tribe(s)	In Attendance	Summary
10/01/04 – 9/30/05	Office of Family Assistance (OFA)	Various Tribal officials and Tribal TANF programs	Tribal officials; Tribal and State TANF staff; Division of Tribal TANF Management, OFA, OA, regional staff	50 meetings and conference calls about general and specific issues related to the Tribal TANF program.
12/7/04	Office of Family Assistance (OFA)	Title IV-D Tribal Grantees	Representatives of IV-D Grantee Tribes; OCSE, OA, Division of Tribal TANF Management staff	Meeting about IV-D program initiative issues as related to Tribal TANF programs.
2/7/05 – 2/10/05	Office of Child Support Enforcement (OCSE)	8 Tribes	18 Tribal attendees	Model Tribal CSE Systems Design Committee Meeting, Phoenix, AZ. Meetings were held for Joint Application Design sessions to design a model automated system for Tribal Child Support Enforcement. These sessions provided a forum for the current grantees to identify the business requirements and needs of their IV-D programs.
4/4/05 – 4/7/05	Office of Child Support Enforcement (OCSE)	10 Tribes	25 Tribal attendees	Model Tribal CSE Systems Design Committee Meeting, Clearwater, FL. *(See above summary of 2/7-10/05 Meeting in Phoenix, AZ.)*
4/19/05 – 4/21/05	Office of Child Support Enforcement (OCSE)	6 Tribes	Approximately 22 Tribal attendees	Meeting at Morongo Indian Reservation in Cabezon, California to consult with grantees and interested Tribes on the Tribal Child Support Final Rule and present the scope and requirements for grant applications: how to prepare a budget request; application requests; and types of funding available.

Date	Sponsor	Tribe(s)	In Attendance	Summary
4/28/05	Office of Community Services (OCS)	Pueblo of Jemez	Representatives Pueblo in Washington, DC; OCS staff	Meetings about the Low Income Home Energy Assistance Program (LIHEAP) and Community Services Block Grant (CSBG).
6/10/05	Children's Bureau (CB)	Acoma Pueblo	Susan Orr, Associate Commissioner	Continuation of New Mexico title IV-E waiver demonstration project
7/18/05 – 7/21/05	Office of Child Support Enforcement (OCSE)	9 Tribes	23 Tribal attendees	Model Tribal CSE Systems Design Committee Meeting, New York, NY. *(See above summary of 2/7-10/05 Meeting in Phoenix, AZ.)*
8/16/05 – 8/17/05	Office of Family Assistance (OFA)	Tribal officials, Tribal TANF and CCDF staff; 29 Tribes from 6 regions	Division of Tribal TANF Management and Region V, VIII, and X staff	Tribal TANF-CCDF Joint Cluster Training and consultation on CCDF and Tribal TANF case management issues.
8/18/05 – 8/19/05	Office of Family Assistance (OFA)	Tribal officials, Tribal TANF staff from 18 Region X Tribal TANF grantees	Division of Tribal TANF Management and Region X staff	ACF Region X Tribal Grantees Conference, which included training and consultation on Tribal TANF issues, reauthorization, reporting issues/forms, etc.

Centers for Medicare and Medicaid Services (CMS)

Date	Tribe(s)	In Attendance	Summary
10/05/05	Lawton Indian Hospital Service United, Lawton, OK	CMS ESRD Clinical Lead, Nephrologists (retired), Service Unit Director (SUD), Physician Assistant, 2 internal medicine physicians	Meeting with Director for IHS Consult regarding Dialysis regarding concern about the potential opening of a dialysis facility by IHS that was raised by the SUD during the HHS Tribal Consultation Session; discussed that IHS continues to not be eligible for Medicare reimbursement for dialysis services.
3/15/05	Kickapoo Nation	Kickapoo Nation Tribal Leaders and Members, CMS Region VII, Other Health and Social Services Providers	Medicare questions were answered and information distributed to those who attended the Health Fair and meeting with Council. Issues discussed included Medicare/Medicaid provider certification of their clinic, program training needs, expertise and resources.
4/16/05	Sac & Fox Nation of Missouri	Sac & Fox Nation Leaders and Members, CMS Region VII, Other Health and Social Services Providers	Medicare questions were answered and information distributed to those who attended the Health Fair.

Health Resources and Services Administration (HRSA)

Date	Tribe(s)	In Attendance	Summary
4/14/05	Navajo Nation, Tuba City, AZ	HRSA staff, IHS staff, Tuba City Regional Healthcare Corporation Board members	Meeting to discuss HRSA's Community Health Center program and whether there might be an opportunity to secure funding for expansion of the present hospital facility serving the Navajo people in Tuba City, AZ.
8/05	Various Tribal organizations	HRSA/Office of Rural Health Policy (ORHP)	All Grantee Meeting Roundtable discussion which provided an update on collaborative activities between the agencies and discussed resources for provision of health services to AI/AN populations.
9/1/05	Eastern Shoshone and Northern Arapahoe Tribes on the Wind River Reservation, WY	HRSA/BPHC, Division of Health Center Development representative	The meeting was arranged by the Primary Care Association to discuss the requirements of the health center program and the next steps the Tribes might take in pursuing grant funding.
2005	Various Tribal organizations	HRSA/BPHC, Division of Policy and Development	Participated in numerous TA and training activities that were attended by Tribal organizations, including training events sponsored by national and State organizations; national pre-application conference calls for all of the announced competitive opportunities to provide technical assistance; and responding to numerous requests for additional information on BPHC programs, requirements and expectations.
2005	Various Tribal organizations	HRSA representatives including rural health, primary care-community health centers, HIV/AIDS	Meeting was arranged with a consortium of Trial entities during conference calls. Follow-up technical assistance was given for grant preparation for applications in Rural Health Outreach and Rural Health Networks in collaboration with Regional Offices.

Indian Health Service (IHS)

During fiscal year 2005, IHS conducted over 60 Tribal Delegation Meetings. Due to this high quantity, only a summary is provided in this report. A complete list of these meetings is available from the Office of Tribal Programs, Indian Health Service.

Date	Tribe(s)	In Attendance	Summary
10/01/04 – 09/30/05	60 Tribal Delegation Meetings	Tribal leaders and representatives; Director of IHS; senior IHS staff	Tribal leaders and representatives consult with the Director, senior IHS staff, and Area Directors in meetings numerous times during the year. A variety of issues are discussed during these meetings, including facilities construction, funding allocation concerns, health care delivery, etc.

Intergovernmental Affairs (IGA)

Date	Tribe(s)	In Attendance	Summary
2/17/05	Alaska Native Tribal Health Consortium (ANTHC)	IGA staff, IHS Director, and Alaska Native Tribal Health Consortium staff	IGA provided policy support for Dr. Charles Grim during the discussions regarding the Indian Health Care Improvement Act and the Commissioned Corps Uniform Policy.
3/2/05	Lummi Indian Nation	IGA/Tribal Affairs staff, Lummi Council member, and Tribal policy staff	IGA staff provided an IGA overview, introduced IGA staff, and conducted a tour of the office and Command Center.
3/2/05	Papa Ola Lokahi	IGA/Tribal Affairs staff, Papa Ola Lokahi representatives	IGA staff invited Papa Ola Lokahi to submit a plan to the ICNAA for involving Native Hawaiians in the consultation process.
3/2/05	Nevada Tribes	IGA staff, IHS staff, Tribal leaders from seven Nevada Tribes	IGA/Tribal Affairs consulted on a number of health care issues including the planned expansion of the Phoenix Indian Medical Center and its impact on the Tribes in Nevada.
4/21/05	Alaska Native Health Board	IGA/Tribal Affairs staff, HHS Assistant Secretary for Legislation, Alaska Native Health Board (ANHB) staff, and IHS representatives	IGA staff convened the meeting to discuss the Dental Therapist Program of the ANHB. Discussion focused on the HHS passage of the Indian Health Care Improvement Act once legislation is introduced.
6/1/05	Nevada Tribes	IGA/Tribal Affairs staff, IGA Director, IHS Director and staff, InterTribal Council of Nevada representatives	IGA/Tribal Affairs convened meeting to follow-up on the concerns about the perceived lack of inclusion by the Nevada Tribes in development of the Phoenix Area Master Plan.
6/20/05	Papa Ola Lokahi	IGA/Tribal Affairs staff, Papa Ola Lokahi (POL) representatives, representatives from ANA, ASL, HRSA, IHS	IGA staff convened the consultation meeting to discuss the interest shown by POL to participate in a budget consultation process similar to that given to Federally recognized Tribes. POL was informed that consultations could take place by means of individual meetings with Regional Offices and Divisions coordinated through the ICNAA.
6/30/05	Navajo Nation	IGA/Tribal Affairs staff, Navajo Nation representatives, Office of the Assistant Secretary for Health representatives	IGA staff participated in the discussion of health services for Navajo veterans, implementation of the MMA/effects on the Navajo Nation, progress on a Navajo Nation trauma center, and health facility construction needs.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Date	Tribe(s)	In Attendance	Summary
5/24/05	Quinalt Tribe, Ocean Shores, WA	SAMHSA Administrator and Acting Deputy Administrator; IGA/ Tribal Affairs staff; Tribal leaders; Tribal behavioral health staff	On this site visit, the Administrator was briefed on the Tribe's mental health and substance abuse programs, and he in turn described SAMHSA's major activities and grant programs, with an emphasis on the Agency's work with Tribes. He was also given a tour of the reservation.
5/26/05	Lummi Tribe, Bellingham, WA	SAMHSA Administrator; IGA/Tribal Affairs staff; Tribal Chairman, Vice Chairman, and Tribal behavioral health staff	On this site visit, the Tribal leaders updated the Administrator on the Tribe's Community Mobilization Against Drugs (CMAD) initiative and provided him with a tour of the reservation. He visited a Tribal high school, college, treatment facility, and domestic violence shelter.

Office for Civil Rights (OCR)

Date	Tribe(s)	In Attendance	Summary
5/13/05	Nevada Urban Indians, Inc. (NUI), Reno, NV	OCR Region IX and NUI staff	OCR gave a presentation on HIPAA and an overview of OCR's jurisdiction to NUI staff.

Region- and Division-Specific Tribal Consultation

Periodically, even though Regional Offices and Divisions participate in National and Regional-Level Tribal Consultation, they may conduct independent sessions at which Tribal consultation occurs. Additionally, ongoing consultation efforts through written communication and other means occur throughout the year.

Region-Specific Tribal Consultation

Sponsor	Date	Consultation	Summary
Region VI	7/11/05	New Mexico Tribal Issues	Regional Director Linda Penn, Executive Officer Don Perkins participated in a conference call with representatives from New Mexico Governor Bill Richardson's office and HHS officials from the IGA, IHS, and ACF. The governor's staff discussed New Mexico's Tribal Infrastructure Act, which provides state seed money to tribes for water, power, road and other improvements. They also discussed concerns regarding funding for the Albuquerque area urban hospital and grant availability for capacity building for tribes in New Mexico.
Region IX	3/16/05	Cross-cutting initiatives for the Bureau of Indian Affairs (BIA) 2005 Action Plan	The Regional Director's Office participated in a Federal Regional Council Tribal Affairs Committee meeting chaired by the Bureau of Indian Affairs. There was also discussion on the shortage of nurses at BIA operated schools in the Navajo Area and an inquiry to see if similar problems exist in the Phoenix, Tucson, or California Areas.
Region IX	2005	CMS certification to participate in the Medicare program	The Regional Director assisted the Fort Defiance Indian Hospital CEO and Navajo Area IHS, in obtaining CMS certification. CMS agreed to move up its timetable for its survey visit.

Division-Specific Tribal Consultation

Administration for Children and Families (ACF)

Date	Consultation	In Attendance	Summary
10/1/04, 11/1/04	Family and Youth Services Bureau (FYSB), FVPS Program annual conferences, Seattle, WA and Oklahoma City, OK	Family Violence Director William Riley, FVPS staff and FYSB Tribal liaison and Tribal social services directors	Presentation to and consultation with community leaders in attendance on Domestic Violence issues.
3/18/05	North Carolina Indian Unity Conference	North Carolina Tribal Members	Administration for Native Americans (ANA) Deputy Commissioner Romine gave a presentation on ANA program update.
4/24/05 – 4/27/05	Child Care Bureau 11th National AI/AN Child Care Conference	ACYF Staff, ACF Regional Staff, TriTAC staff; Tribal Child Care Directors, and staff	HHS Staff spoke at Opening Plenary Session on Good Start, Grow Smart, the President's Early Learning Initiative, and listened to Tribal research projects in a plenary presentation.

Date	Consultation	In Attendance	Summary
5/05, 6/05	Administration for Children and Families Region VI Tribal Roundtables	Tribal Child Care, Tribal Child Welfare, Tribal Child Support and ANA grantees; Region VI ACF Program Specialists in Tribal Child Care, Tribal Child Support and Tribal Child Welfare	ACF Region VI conducted two Tribal Roundtables in Oklahoma and New Mexico. During the two roundtable meetings, over 40 Tribes were represented with approximately 200 people attending the three day meetings. Workshop topics included Tribal Child Support Enforcement, Developmental Disabilities Services, Working with Parents with Mental Health Issues, Methamphetamine Labs and the Impact on Children and Families and a Tribal Child Care Directors' Forum.
5/18/05	Speech for Tribes	Affiliated Tribes Northwest Indians	Administration for Native Americans (ANA) Commissioner Stamps gave a speech.
6/1/05	National Low-Income Energy Consortium conference, Phoenix, AZ	OCS, representatives from more than 30 Tribes, other home energy and energy assistance providers	OCS sponsored 2 interactive Tribal workshops on the Low Income Home Energy Assistance Program. Also, OCS staff met with Tribal representatives to discuss the Tribes' LIHEAP programs.
6/22/05 – 6/24/05	Smart Marriages Conference	ANA Deputy Commissioner Romine and Native American marriage program representatives	Roundtable discussion with Native American Program representatives
7/15/05	Tribal Civilian Conservation Corps, Nenana, AK	Commissioner Stamps	Administration for Native Americans (ANA) Commissioner Stamps gave a speech.
8/25/05	State/Tribal Meeting hosted by Children's Bureau	128 individuals representing Tribes, States, advocacy groups, Resource Centers, Federal Central Office and Regional staff	Discussion of ICWA issues between States and Tribes including notices; discussion of state/Tribal relationships and implementation of Federal policy.
2005	Office of Community Services (OCS) technical assistance	OCS staff, OCS Tribal grantees, and potential Tribal grantees	Providing training and technical assistance, information, and consultation about OCS programs through telephone and written contacts and meetings.

Administration on Aging (AoA)

Date	Consultation	In Attendance	Summary
4/28/05	Tribal Listening Session	Assistant Secretary for Aging, AoA Staff and about 250 Tribal leaders, staff, and elders	Issues discussed included Title VI services and funding concerns, concerns abut inadequate funding for health care, increasing elder abuse, increased flexibility for home and community based services funding by all components of HHS, combating discrimination, environmental issues.

Centers for Disease Control and Prevention (CDC)

Date	Consultation	In Attendance	Summary
5/25/05	Dear Tribal Leader Letter	Non applicable	The CDC Director sent a letter to every Tribal Government, national Tribal Organization, and Regional Tribal Health Board informing them of the draft CDC Tribal Consultation Policy and requesting comments with all aspects of the policy.
6/05	Series of regional meetings	COTPER, NIP, states, Area IHS Director and Medical Directors, and Tribal Epi Centers representatives	COTPER assisted the National Immunization Program (NIP) in pandemic flu preparedness for Tribal nations by hosting meetings in which stakeholders came together to review state pandemic plans to discuss how state planners have addressed Tribal partner in their plans and involve Tribal entities in the state influenza planning processes.
9/30/05	Dear Tribal Leader Letter	Non applicable	The CDC Director informed Tribal leaders of the intent to publish the proposed changes in the *Federal Register* as a Notice of Proposed Rule Making. Requested Tribal comments regarding the implications of proposed quarantine regulations changes in Indian Country.
2005	REACH 2010 data sharing agreement negotiations	REACH 2010 AI/AN communities: Choctaw Nation, Albuquerque Area Indian Health Board, Association of American Indian Physicians, Chugachmuit Inc., Eastern Band of Cherokee Indians, National Indian Council on Aging, USET, OK State Department, and CDC REACH staff	Draft agreement is under review to establish a framework of principles and procedures to guide data sharing. The overarching aims of this agreement are to maximize the benefits of the REACH Program and to respect and protect the integrity of the communities it serves. This agreement will outline protocols and responsibilities for all partners related to data: ownership; access; storage; confidentiality; dissemination; and disposition.
2005	COTPER Tribal Consultation Sessions and 12 Tribal site visits	COTPER Tribal Liaison, other Division staff and other Federal representatives; Seneca, Tuscarora, Penobscot, Holton Band of Maliseets, Standing Rock Sioux, Three Affiliated Tribes (Manda, Hidatsa, Arikara), Seminole, Passamaquoddy Pleasant Point, local health officials	Discussions focused on how to facilitate broader Tribal participation in terrorism preparedness activities that will allow Federal staff to better understand bioterrorism/preparedness issues in Indian Country. Strategic planning discussed ways to ensure states are applying Federal resources in ways that meet needs of Tribes. Tribal recommendations received were instrumental in applying specific language to the 2005 Cooperative Agreement Announcement requiring states needing to document and describe the process used by their state health department to engage Tribes in these activities.
2005	Recently initiated effort to explore the feasibility and map out a “blueprint” for state and local health agency accreditation.	CDC, Robert Wood Johnson Foundation, Association of State and Territorial Health Officers (ASTHO), National Association of County and City Health Officials (NACCHO), Tribal leader representatives	A Steering Committee has been convened to explore issue and develop the blueprint. Tribal leaders are represented and NIHB will be following deliberations closely.

Date	Consultation	In Attendance	Summary
2005	CDC National Diabetes Education Program (NDEP) AI/AN Workgroup	NDEP, IHS, Association of American Indian Physicians Association, Tribal leaders and community members, and other partner organizations in states.	Working with NIH, an extensive partnership network was formed to improve the way diabetes is treated and assist with the development of culturally appropriate ads for Tribal communities. With input from Tribal leaders and communities, the campaign message "Control Your Diabetes for Future Generations" was created. The Association of American Indian Physicians was selected to help disseminate materials. The workgroup developed a youth-focused campaign, "Move It!" and a campaign for adults at risk for diabetes, "We have the power to prevent diabetes."
2001-2005	CDC National Diabetes Wellness Program (NDWP) seeks Tribal Guidance in implementing work plan	NDWP staff, the Tribal Leaders Diabetes Committee (TLDC), IHS Division of Diabetes Treatment and Prevention, National Institute of Diabetes, and NIH	TLDC suggested the development of a "children's book series" to teach children about promoting health and preventing diabetes using the tradition of storytelling and a DVD that supports the role of a community health worker as the bridge between community and the health care system. An "Eagle Book" series of four illustrated children's books has been developed as has a DVD called "The In-Between People: Community Health Workers in the Circle of Care;" both are being broadly disseminated.
2004-2005	Development of CDC Tribal Consultation Policy	CDC, Consultation Policy Workgroup, NIHB, Regional Health Boards, national Tribal Organizations, Tribal Leaders, TCUs, AI/AN community members	CDC Director signed and officially released the CDC/ATSDR Tribal Consultation Policy. It is felt that this policy and its implementation agency wide will provide for meaningful and effective Tribal consultation leading to enhanced communication, stronger partnerships, and ultimately safer and healthier AI/AN communities.

Centers for Medicare and Medicaid Services (CMS)

Date	Consultation	In Attendance	Summary
6/27/05	CMS Open Door Forum	CMS Central and Regional Office Staff, SSA, IHS	Review Medicare prescription drug coverage as it relates to I/T/Us and provide follow-up to concerns that have surfaced since the IHS/CMS awareness trainings

Health Resources and Services Administration (HRSA)

Date	Consultation	In Attendance	Summary
10/1/04	340B Drug Pricing Program	HRSA/Health Systems Bureau, Office of Pharmacy Affairs (OPA) staff	As of November 28, 110 Tribal health centers and 17 Urban Indian organizations participate in the 340B Program. Indian Tribes who have a Tribal Contract/Compact with IHS are eligible to participate in the 340B Drug Pricing Program.
8/1/05	HRSA/ORHP All Grantee Meeting	HRSA/ORHP staff and IHS representatives	Conducted an AI/AN Roundtable Discussion to provide an update on collaborative activities between the agencies and discuss resources for health services provision to AI/AN populations. HRSA and IHS representatives served as panelists to an audience of

Date	Consultation	In Attendance	Summary
8/1/05	HRSA/ORHP All Grantee Meeting (continued)	See previous page.	grantees with a variety of interests in AI/AN populations and informed audience of ways to better serve AI/ANs through grant opportunities and other collaborative methods.
2005	NHSC Annual Scholar Conferences	HRSA/Bureau of Health Professions, Division of NHSC	IHS participated in 2 Recruitment Fairs. Scholars demonstrated increased interest in employment opportunities with the IHS.

Indian Health Service (IHS)

Date	Consultation	In Attendance	Summary
4/20/05 – 8/22/05	Dear Tribal Leader Letters	Non applicable	The Director forwarded a DTLL to every Tribal Government regarding the following topics: • Notification about an IHS and SAMHSA behavioral health conference to consult on strategies to address behavioral health issues • The policy that governs carryover funding for IHS-awarded grants • Requesting comments on a proposal solicitator for the IHS Small Ambulatory Program • Participation in a national subscription to Micromedex, a series of medication-related informational databases • Issues affecting Federal employees detailed to Tribally operated health programs
2005	National Indian Health Board (NIHB)	NIHB Board of Directors, IHS Director and other IHS staff	The Board, which is comprised of Tribal Leaders and representatives, met on a quarterly basis with the Director and other IHS staff. The NIHB is a source of ongoing advice and consultation to IHS on a variety of matters affecting the IHS budget, national Indian health delivery issues, collaborations with State governments and other Federal agencies, etc.

Intergovernmental Affairs (IGA)

Date	Consultation	In Attendance	Summary
4/24/05 – 4/26/05	Mrs. Bush Helping America's Youth Initiative Native American Outreach	IGA/Tribal Affairs staff, White House Domestic Policy Council members, HHS staff, IHS Director, Salt River Maricopa Tribal leaders and members, and Heard Museum staff	IGA/Tribal Affairs provided technical assistance for the HHS policy team that developed Mrs. Bush's Helping America's Youth (HAY) Initiative and invited over 40 Tribes in Arizona/Nevada.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Date	Event	In Attendance	Summary
6/28/05 – 6/30/05	IHS/SAMHSA Behavioral Health Summit	Tribes and Tribal organizations, HHS Staff; Departments of Justice, Interior, and Education staff; State representatives; and international visitors (Mexico, New Zealand, Australia)	This annual national event has been increasingly well attended for the past three years. A Best Practices forum, organized by CSAT and One Sky, preceded the start of this year's summit and was attended not only by SAMHSA Tribal grantees but a number of Tribal representatives who arrived early for that purpose. Among the workshops was one on Tribal consultation. The summit entailed workshops and plenary sessions around the theme of the conference, "Alcohol, Substance Abuse and Mental Health: Weaving Visions for a Healthy Future."

TRIBAL CONFERENCES AND SUMMITS

In addition to the consultation sessions facilitated and led by HHS, there are a number of Tribal conferences and summits that occur throughout the year at the regional and national levels, organized by Tribal Groups and Organizations, such as the National Congress of American Indians (NCAI) and the Tribal Self-Governance Advisory Committee. This report shares information about meetings in which HHS leadership were invited to participate and speak.

REGIONAL PARTICIPATION

Region	Date	Event	Summary
Region I	6/28/05	USET Semi-Annual Meeting, Mashantucket, CT	Regional Director Brian Cresta and IGA Specialist David Abdoo attended this meeting. Mr. Cresta provided testimony before the USET Board of Directors and answered questions from Tribal leaders. In addition, Mr. Cresta met with Tribal Health Directors from all Federally recognized Tribes in New England.
Region VI	4/25/05	Second Annual Direct Service Tribes Conference, Albuquerque, NM	Regional Director Linda Penn, as a surrogate for IGA Director Regina Schofield, brought greetings on behalf of Secretary Leavitt and the Director. Her remarks covered Secretary Leavitt's commitment to continue a vibrant relationship with Native Americans and Alaska Natives. Additionally, Ms. Penn discussed areas of progress over the past three years that resulted from the regional consultation process.
Region VI	6/1/05	National Indian Women's Health Resource Center's Young Women's Tribal Health Summit, Shawnee, OK	ACF Tribal Team Leader and Tribal Program Specialist participated in Summit planning and training sessions. The objective of the Summit was to provide, disseminate, and discuss information on topics that promote healthy lifestyles to empower young Indian women to make healthy choices, introduce them to new health behaviors, promote development of leadership skills by providing positive role models who exhibit and teach leadership qualities, and establish a network for interaction and information exchange.
Region VIII	5/05	Prevention of Cardiovascular Disease & Diabetes Among American Indian and Alaska Natives conference, Denver, CO	Regional Director attended the conference.
Region X	11/4/04	American Indian Health Commission for Washington State Tribal Health Summit, Bow, WA	Regional Director and IGA Specialist attended the summit.
Region X	11/9/04	Tribal Self-Governance Conference, Seattle, WA	Region X Regional Director gave welcoming remarks.
Region X	4/18/05	Tribal Self-Governance Conference, San Diego, CA	Acting Regional Director attended the conference and met with Tribal leaders from WA and AK.
Region X	5/18/05	Affiliated Tribes of Northwest Indians	Acting Regional Director attended the meeting in Tacoma, WA.

Region	Date	Event	Summary
Region X	7/25/05 – 7/29/05	Foster Care and Native Alaska Children	Region X ACF Child Welfare Staff, Casey Family Programs, Native Alaskan Partners, State Legislature, and Department of Health & Social Services attended this conference, which reviewed the disproportional participation of Native Alaskan Children in Foster Care.

DIVISION PARTICIPATION

Administration for Children and Families (ACF)

Date	Sponsor	Event	Summary
2/1/05	Family and Youth Services Bureau (FYSB)	Mentoring Children of Prisoners annual conference	Associate Commissioner Harry Wilson, FYSB leadership and staff met one-on-one with representatives of Tribal MCP grantees from across the nation regarding MCP issues.
4/24/05 – 4/27/05	Administration for Native Americans (ANA)	11th National AI/AN Child Care Conference	Deputy Commissioner Romine, ACF Staff and Tribal Child Care representatives were in attendance. Romine gave a presentation on Native American Healthy Marriage Initiative.
5/1/05	Family and Youth Services Bureau (FYSB)	National Boys and Girls Club meeting in San Diego, CA	Associate Commissioner Harry Wilson, FYSB leadership and staff met one-on-one with representatives of Tribal MCP grantees from across the nation regarding MCP issues.
5/16/05	Administration for Native Americans (ANA)	Region V Native American Conference	Deputy Commissioner Romine and Region V Area Tribal representatives were in attendance. Romine gave a presentation on Native American Healthy Marriage Initiative and ANA Commissioner Stamps gave a speech.

Centers for Disease Control and Prevention (CDC), Coordinating Office of Terrorism Preparedness and Emergency Response (COTPER)

Date	Event	In Attendance	Summary
10/04, 4/05, and 7/05	Louisville Metro and Phoenix Community Based Emergency Response Training Programs and “Four Corners Bioterrorism Tribal Summit Conference”	Eastern and western Tribal entities, Tribal nations from AZ, NM, UT, and CO	All focused on identifying, framing and examining issues surrounding a coordinated response to bioterrorism and emergency preparedness affecting Tribal nations in these regions.

Indian Health Service (IHS)

Date	Event	In Attendance	Summary
4/25/05 – 4/28/05	Direct Service Tribes National Conference, Albuquerque, NM	Approximately 400 Tribal Leaders and representatives met with the IHS Director, senior staff, Area Directors, and other staff; HHS staff from IGA and Regional Offices.	Discussions focused on the budget, 3rd party collections, contract health services. The Director signed a charter creating a National Direct Service Tribes Advisory Committee.
5/2/05 – 5/4/05	National Tribal Self-Governance, San Diego, CA	Approximately 400 Tribal Leaders and representatives; IHS Director, senior staff, Area Directors, and other staff; HHS staff from IGA and Regional Offices	Discussions focused on contract support cost issues, the budget formulation process, the HHS and IHS consultation policies and other issues.

Intergovernmental Affairs (IGA)

Date	Event	In Attendance	Summary
1/23/05	Tribal Self-Governance Advisory Committee Quarterly Meeting (TSGAC)	IGA staff, TSGAC committee members	IGA presented on the HHS transition, the Indian Health Care Improvement Act, HHS Tribal consultation policy/sessions, and HHS Barriers Study
2/7/05	United South and Eastern Tribes (USET) Impact Week	IGA staff, USET Health Committee members	IGA/Tribal Affairs staff presented on the HHS organization and intergovernmental responsibilities.
3/1/05	National Congress of American Indians (NCAI) Executive Council Winter Session	IGA/Tribal Affairs staff, Congressional Members, NCAI staff	IGA/Tribal Affairs staff attended sessions involving topics regarding Trust Reform, Gaming, the Native Vote Initiative, and Social Security Reform.
3/2/05	NICOA and NCAI) Indian Elders Meeting	IGA Director, IGA/Tribal Affairs staff, AoA staff, NICOA Chairman, NCAI staff	IGA provided technical support/assistance and provided an update on the HHS White House Advisory Committee nominees.
5/2/05 – 5/4/05	National Tribal Self-Governance Conference	IGA staff, IGA Director, IHS Director	IGA Director made the HHS keynote speech and presented a legislative report for the Office of the Assistant Secretary for Budget, Technology, and Finance. IGA/Tribal Affairs staff conducted a joint session with IHS staff on the revised HHS Tribal Consultation Policy and draft IHS Tribal Consultation policy.
6/13/05 – 6/14/05	National Congress of American Indians (NCAI) Mid-Year Conference	IGA/Tribal Affairs staff, NCAI staff, former HHS Secretary Tommy Thompson	IGA/Tribal Affairs staff attended various sessions and responded to questions about the desire of NCAI's Human Resources Committee to include Tribal voting representation on the Medicaid Reform Commission.

National Institutes of Health (NIH)

Date	Event	In Attendance	Summary
03/15/05 – 03/18/05	NICHD-sponsored workshop: "Improving Academic Performance Among Native American Students: Assessment and Identification of Learning Disabilities" (Santa Fe, NM)	NICHD scientific program staff, Native American community representatives, Bureau of Indian Affairs, Department of Education, and representatives from multiple universities	Participants discussed the current state of educational instruction and assessment practices, cognitive development, and underlying theories and research, and the relationship of these factors to academic performance of Native American children. Participants also consulted on expanding efforts to improve academic performance of Native American children.
08/01/05	Association of American Indian Physicians (AAIP) Annual Meeting	NCMHD Director; attendees included physicians, researchers, scientists, community leaders and Federal officials from the AI/NA community and representing agencies engaged in work related to the health of the AI/NA community.	NCMHD Director gave a key note address on opportunities available for the Native American/American Indian community to partner with the National Center on Minority Health and Health Disparities to eliminate health disparities among Tribal populations.
08/17/05	Follow-up of earlier Improving Academic Performance Among Native American Students workshop Washington, DC	NICHD staff, Native American community representatives, Bureau of Indian Affairs, Department of Education, and representatives from various universities	Participants discussed outcomes of the earlier Sante Fe workshop. Participants also consulted on how to expand efforts to improve academic performance of Native American children.
09/29/05 – 10/02/05	Consultations and outreach at the annual meeting of the Society for Advancement of Chicanos and Native Americans in Science (SACNAS), Denver, CO	Director of NICHD Extramural Associates Program and other meeting participants including students, educators, administrators, and researchers in the scientific field	The meeting was to enable students, educators, administrators, and researchers in the scientific field to share research information; address the unique accomplishments and challenges of Native Americans and Chicano/Latinos in science; form networks and strengthen mentoring and collegial relationships; and gain access to educational and career opportunities. The Director of Extramural Associates Program met with conference attendees and distributed literature in an effort to recruit participants for the EARDA program.
2005	Consultations at University of New Mexico, Gallup, NM	Deputy Director of NICHD, Director of NICHD Extramural Associates Program, President of New Mexico Highland University, EARDA grantee	Consultations in person and by teleconference, with EARDA grantee on her responsibilities, supported by a NICHD supplement, for outreach activities to recruit Tribal colleges and universities into the Extramural Associates program and related matters.

Section 3

Outcomes and Accomplishments

SECTION 3: OUTCOMES AND ACCOMPLISHMENTS

MAJOR HHS OUTCOMES AND ACCOMPLISHMENTS

Increased HHS Tribal Funding: Between fiscal year 2002 and 2005, HHS funds expended for Tribes increased by $530,292,611and 12.84 percent. For 2005, HHS resources that were provided to Tribes or expended for the benefit of Tribes increased to approximately $4.66 billion, an increase of approximately $95.5 million over the 2004 amount of $4.57 billion. These gains came in both appropriated funding as well as increased Tribal access to non-earmarked funds and increases in discretionary set asides. (See Tables 1 and 2 in Appendix D for detailed budget figures).

HHS Tribal Consultation Policy: In FY04, the Office of Intergovernmental Affairs (IGA), in partnership with the IHS, undertook a review of the current Tribal Consultation Policies in both HHS and IHS. Following much work at the staff level in FY04, the OS/IHS Tribal Consultation Policy Revision Workgroup (TCPRW) completed its initial draft report. This report was forwarded to all Tribes on October 1, 2004, for review and comment. The Workgroup reconvened in December 2004 to consider comments received and complete work on the HHS policy. Former Secretary Thompson signed the revised HHS Tribal Consultation Policy on January 14, 2005 and Secretary Leavitt transmitted the policy to Tribes on March 11, 2005.

Regional Tribal Consultation Sessions/Annual Tribal Budget Consultation Session: In 2005, HHS Regional Directors coordinated nine regional Tribal consultation sessions. Results of these sessions are documented in this report. On May 17-18, HHS held its 7th Annual Tribal Budget Consultation Session. This session was expanded to one and a half days at the request of Tribal leaders and provided the opportunity for Tribes to discuss their health and human services priorities with HHS officials.

Intradepartmental Council for Native American Affairs: The Intradepartmental Council for Native American Affairs met twice in 2005. The Council membership includes the heads of each HHS Division and serves as the Secretary’s principal advisory body on Tribal policy matters. Seven ICNAA Priorities for FY05 include: Health Promotion and Disease Prevention, Tribal Consultation, Increase Effectiveness of Human Services with Native Populations, Health Professions Recruitment, Emergency Preparedness, Increasing AI/AN/NA Access to HHS Programs, Consolidation of Technical Assistance.

Federal-Tribal-State Human Services Collaboration: In October 2003 (FY04), the Secretary partnered with the National Congress of American Indians (NCAI) and the American Public Human Services Association (APHSA), which serves the states and territories, to work collectively on human services priorities and issues to share information, best practices and promising approaches for more efficient and effective service delivery. This unique project continues for FY05 because of its success in raising awareness of the need and value of intergovernmental collaboration. All three groups noted a change in their respective organizational culture and joint participation in hearings, national meetings and in the HHS regulatory process because of the broadened dialogue created through this collaboration project. It was recommended and IGA approved that the Project continue for FY05 to create more gains based on this year’s outcomes with an emphasis on developing web-based and printed resource materials, documenting best practices, and enhancing electronic intergovernmental communications. (See Appendix E for the Collaboration’s Final report.)

Medicare Part D Implementation: With the initiation of the Medicare Modernization Act (MMA) on January 1, 2006, HHS regions and divisions, in particular, CMS, IGA, and IHS, prepared for its implementation in Indian Country throughout FY05. The CMS Tribal Technical Advisory Group (TTAG) played an integral role in assisting HHS divisions in developing an approach to include Tribes in the implementation process. Numerous meetings, exhibits, presentations, and consultations were conducted with Tribes and Tribal audiences for the purposes of awareness, education, outreach, and training about the new Medicare Part D prescription drug coverage plan. Frequent issues discussed included Medicare Part D's impact for Tribal beneficiaries; identification of training needs, developing culturally appropriate training materials, planning and coordinating IHS area trainings, development, and implementation; eligibility/enrollment guidelines; AI/AN data needs; development of contract between Part D plans and I/T/Us; dual eligibles (those eligible for Medicaid and Medicare Part D); the number of prescription drug plans that will serve Indian Country; key AI/AN outreach messages and products.

HHS Response to Red Lake: The Department responded to the tragic shooting in Red Lake with sensitivity to the Tribe's sovereignty. A small team was deployed to the reservation to coordinate resources, deliver essential health-related services, and provide technical assistance as requested by the Tribe. HHS organized an intradepartmental team, comprised of representatives from the Immediate Office of the Secretary, Office of Intergovernmental Affairs, ICNAA, Indian Health Service, Administration for Children and Families, Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, Office of Public Health and Science, Office of Minority Health, and the Region V Coordination Team. HHS responded to specific Tribal requests by deploying staff from Headquarters, HHS Bemidji Area Office, HHS Region V Office in Chicago, and a team of Commissioned Corps Officers to provide immediate mental health services and relief to the IHS staff at the Red Lake Hospital.

HHS Response to Hurricanes Katrina and Rita: The Office of Intergovernmental Affairs (IGA) worked closely with the Tribal Liaison network of the ICNAA to provide information on the status and needs of the seven Federally recognized affected by Hurricanes Katrina and Rita. IGA staff prepared daily reports that included information on the needs of each Tribe as well as press reports from the Tribal press outlets. As the acute response phase passed, IGA staff was in direct contact all seven Tribes in the Gulf region and assisted in facilitating communications between the Tribes and those organizations responding, including FEMA. IGA was also in contact with the Louisiana Governor's Office of Indian Affairs and shared information on HHS Grants for which Louisiana State Recognized Tribes are eligible.

First Lady's Visit to Indian Country – Helping America's Youth: On April 27, First Lady Laura Bush visited Phoenix, AZ and held an event to focus attention on the needs of American Indian and Alaska Native youth. She met with Tribal officials from the southwest to discuss the Helping America's Youth initiative and visited the Phoenix Urban Indian program.

REGIONAL OUTCOMES AND ACCOMPLISHMENTS

Region I

Grant Funding: The Regional Office continues to send grant announcements to Tribal staff and leaders on HHS division grants and funding opportunities.

SAMHSA Grant Assistance: The Passamaquoddy Tribe at Pleasant Point had, for the second straight year, received an unsuccessful score on their SAMHSA Target Capacity Expansion (TCE) Grant. The Regional Office assisted in getting SAMHSA approval and funding for the hiring of a consultant from One Sky to assist the Tribe in reviewing their grant applications from the past two years and developed a better proposal for the coming year's application. The consultant spent one week on site with the Tribe health staff and leadership and provided a thorough review of the submissions and assistance with developing a better application for future SAMHSA funding.

Medicare: The Regional Office continued its strong working relationship with the Tribes in New England in training for the upcoming Medicare Modernization Act prescription drug benefit. The Regional Office provided an in-depth one day training for all Tribal staff and leaders on May 20th. The Regional Office held a one-day training for health and human services staff and Tribal leaders for the Tribes in Maine on CMS's WebFinder Tool. The web-based tool assists individuals in determining the most appropriate prescription drug plan to enroll a beneficiary into. Tribal staff were prepared to assist in enrollment and re-enrollment for Tribal members.

Medicaid: During the past two years of Tribal Consultation, the Wampanoag Tribe of Acquinnah and the North American Indian Center of Boston, both in Massachusetts, have requested assistance with obtaining reimbursement from the Massachusetts Department of Medical Assistance for the administrative costs associated with enrolling members into the state's Medicaid Program (MassHealth). After considerable negotiations and discussions with the state, HHS was able to obtain an agreement with Massachusetts that these Tribes would be reimbursed through a grant system for costs associated with Medicaid enrollment.

Region II

As a result of the 2005 Regional Consultation Session, the following outcomes occurred:

1. New York State has made progress in resolving a number of long-standing issues, such as the pay-and-chase activities undertaken by county offices and the need to pay for Tribal members to use culturally sensitive out-of-state facilities, such as the Unity House and Four Winds.
2. New York State has instituted a State Pharmaceutical Assistance (SPA) program which had long been sought by the Tribes.
3. New York State has instituted a program of providing technical assistance to Tribes regarding Medicaid and other health related reporting requirements.
4. Region II OPHS sponsored a Suicide Prevention Summit in the Albany, New York, area, where many issues related to suicide awareness and prevention specific to the Tribes were addressed. Tribes were provided significant opportunities for input and participation.
5. Regional ACF office has provided assistance to Tribes regarding child support enforcement activities.
6. Per the request of the Tribes, AoA is accepting population and demographic figures provided by the Tribes instead of the Census Bureau.
7. Tribes have been assisted by the Office of the Regional Director in accessing Federal grant opportunities, including technical assistance navigating Grants.gov.

8. New York State Office of Children and Family Services used the Tribal consultation process to develop the Tribal strategies included in the New York State Child and Family Services Program Improvement Plan.
9. New York State has provided the Tribes with a training DVD on the Indian Child Welfare Act.
10. With the assistance of the New York State Medicaid Office and CMS, the Tribes have initiated the process to receive certification as a pharmacy DME supplier.

Region V

Emergency/Pandemic Preparedness: As follow-up to the Consultation Session, the Acting Regional Director provided HHS bioterrorism funding information to Michigan Tribal staff. Additionally, Region V Office of the Regional Director is working with Tribal organizations on pandemic preparedness, including outreach to Tribes on state summits and providing information on national briefings.

SAMHSA Grant Program: As follow-up to the Consultation Session, SAMHSA provided detailed information on their Mental Health Transformation State Incentive Grant Program to specific Tribal participants, including pre-application technical assistance plans.

Red Lake Response: See Section II: Red Lake Response.

Tribal Human Services Conference: On May 17, the Acting Regional Director opened the Region V ACF Tribal Conference in Minnesota, highlighting Secretary Leavitt's commitment to a strong government-to-government relationship, and consultation, to meet the health and human services needs in Indian Country. The Acting Regional Director stressed the importance of Bemidji-area Tribes to have a voice nationally, due to the highest rates of deaths by cancer and heart disease proportionally, as well as issues/follow-up to the Midwest budget session in March 2005. The Acting Regional Director also highlighted the Federal response to Red Lake, and then separately dialogued with the Red Lake Secretary, the Minnesota State Human Service Tribal Liaison, and ACF leadership on child welfare concerns.

National Tribal Consultation Session: Oneida's Government Affairs Liaison and the Acting Regional Director worked to confirm a Bemidji-area Tribal spokesperson for the 2005 national consultation session, as follow-up to a Regional session recommendation (no area leadership participated last year). Oneida's Vice-Chair Kathy Hughes confirmed participation. On May 18, the Acting Regional Director attended the national Tribal budget consultation session in response to the Oneida Government Affairs Liaison's request during the planning of the Regional Session earlier this year.

Medicare Prescription Drug Benefit: The Office of the Regional Director and CMS worked with the Regional Tribal community on the new drug benefit. CMS staff participated in numerous Tribal meetings across the Region, including technical workshops at Tribal health directors meetings in Michigan and Minnesota, highlighting the new benefit and addressing concerns.

Region VI

ACF's Tribal Team Leader, maintained frequent contact with four Tribes in Louisiana and one Tribe in Texas affected by Hurricanes Katrina and Rita. One Tribe in Louisiana requested additional funding to support services to children and families seeking child care services. Through negotiations with the Child Care Bureau, Regional Office, and Tribe, additional funding was provided to support the unanticipated increase in child care related need for services.

At the 2005 Region VI Tribal Consultation, Pueblo of Acoma representatives inquired to Judy Baggett regarding ACF Tribal programs: Tribal TANF and CSE. She directed the representatives to Carl Rich, TCSE Coordinator. Since the consultation, ACF Regional Office has conducted two formal meetings to discuss TCSE and TANF. We also participated in two conference calls with Acoma and Central Office. Acoma has subsequently submitted a letter of intent to operate a Tribal TANF program.

Region VII

As a result of the 2005 Regional Consultation Session, the following outcomes occurred:

1. The Tribes shared Best Practices and issues.

2. Dr. Grim, IHS, through the Aberdeen Area IHS office sent follow-up letters to:
   - Chairman Cayou, Omaha Tribe of Nebraska, on June 9, as a follow-up to a request for technical assistance in learning third-party billing procedures for their new wellness center. The correspondence offered a training session for July 11 to 13.
   - Chairman Peniska, Northern Ponca Tribe, on June 15, through the Aberdeen Area IHS office, addressing several issues of concern to the Tribe, including service unit status and credit, challenges with data entry for Alcohol Program reporting system, difficulties with system connection for data located at satellite facilities, and inquiry into whether the Ponca Tribe could be considered for a Program Assessment Rating Tool review.
   - Chairman Trudell, Santee Sioux Nation, on June 9, through the Aberdeen Area IHS office, addressing several issues of concern to the Santee Sioux, including the Tribe's dissatisfaction that their Contract Health Services Program is limited to Priority 1, request for permission to screen every patient for diabetes when they are seen at the clinic, concern about Medicare and Medicaid enrollment seen as "weaning the Tribes off IHS," and concern that Tribes will be identified during their Program Assessment Rating Tool reviews.

3. The Administration for Children and Families follow-up included:
   - Providing technical assistance in grant writing to the Kickapoo Nation.
   - Providing ongoing technical assistance on Child Care issues to all Region VII Tribes.
   - Providing ongoing technical assistance for specific Tribes that are interested in or have applied for the operation of their own Child Support Enforcement program.

4. The Administration on Aging follow-up included:
   - A report on the new three-year grant period that began for Region VII Title VI grantees on April 1 and the reporting requirements. At the National Title VI Training and Technical Assistance Forum that was held April 25 to 28 in Arlington, Virginia, it was announced that reporting would be on an annual basis effective with the grant period beginning April 1. In talking with the grantees after the conference, all were very receptive to the reduced reporting requirements.
   - Letters were sent to Region VII Title VI Directors encouraging them to join AoA, CMS, and the SSA in providing information and educational outreach to all Tribal Medicare recipients. Reports from the Title VI Directors indicated that on June 10 and June 21, open training sessions were held by the Social Security Administration at the Iowa Tribe of Kansas and Nebraska and Prairie Band Potawatomi Tribe. On June 14, an open training session was held by the IHS at the Kickapoo Tribe. Staff from the Omaha Tribe, the Santee Sioux Tribe, and the Winnebago Tribe of Nebraska attended the June 2 Medicare Prescription Drug Benefit (Part D) Training session in Aberdeen, South Dakota.

5. The Centers for Medicare and Medicaid Services follow-up included:
   - Participation at the Sac and Fox of Missouri health fair in April providing Medicare prescription drug education and outreach.
   - Coordinated the IHS Medicare awareness training for Indian Country, specifically Oklahoma and Aberdeen IHS area offices, in May and June in accordance with the IHS/CMS interagency agreement.
   - In April, CMS participated in the Nebraska inter-Tribal health coalition diabetes conference in South Sioux City, Nebraska. CMS supported the conference financially and conducted outreach for the Medicare Part D education effort.
   - Assisted the Kickapoo Nation in preparing an article for their Tribal newsletter regarding Medicare and the new prescription drug coverage and how it affects Indian Country.
   - Sent a “Dear Tribal Leader” letter in June describing Medicare group payor option for Part B.
   - Provided policy clarification to the Kickapoo Nation pharmacists regarding reimbursement of pharmaceuticals and the all-inclusive rate.
   - Provided information to the Omaha Tribe on Medicaid administrative matching and provided State contact information. Was this just regional?
   - In June, CMS sent Medicare prescription drug literature and give-aways to the Santee Sioux Nation for their health fair.

6. The Office of Public Health and Science followed up in several areas discussed at the FY05 and previous Tribal consultations. This included:

   - Sponsorship of the Nebraska Inter-Tribal Health Coalition’s conference titled: “Cultural Rebirth: New Approaches to Living with Diabetes, held April 18-20 in South Sioux City, NE, which was directed at Tribal members suffering from diabetes and health professionals who serve them. The conference was planned by the Nebraska Inter-Tribal Health Coalition, which received modest core financial support with OPHS Region VII Office of Minority Health Funds. All Tribes in Region VII were invited; Tribal representation was good. Attendees had access to a variety of health screenings including body composition analysis, cholesterol, blood pressure, and blood sugar screenings. Additionally, information from a variety of organizations was available. Tribes had a poster session which featured programs developed and implemented to address diabetes prevention, management, fitness, and diet.
   - On April 21, the Minority Health Coordinator and Deputy Regional Health Administrator visited the new Winnebago Tribal Hospital in Winnebago, KS. They met with the CEO and other staff. They also went to Macy, NE and visited the Omaha Tribe Medical facility.
   - In June, the Office of Public Health and Science served as a sponsor of the Tribal Youth Power of Choice program in South Sioux City, NE. Youth from the Omaha Tribe of Nebraska, Prairie Band Potawatomi Nation and the Winnebago Tribe of Nebraska participated in the program to promote healthy choices for Tribal youth.
   - In September, the Office of Public Health was one of the sponsors of the Kansas City Obesity Conference at which Native American Olympian, Billy Mills, was a keynote speaker. OPHS sponsored the participation of several Tribal representatives at this conference.
   - The Region VII Medical Reserve Coordinator met with the emergency response manager of the Prairie Band Potawatomi Nation to explore possibilities for establishing a pilot MRC unit on this reservation. These explorations are continuing.

Region VIII

As a result of the 2005 Regional Consultation Session, the following outcomes occurred:

1. Region VIII Tribes were given an opportunity to present issues of concern to Region VIII officials.
2. Facilitated informal discussions between Tribal representatives and representatives of several Federal agencies.
3. Written HHS program material was distributed to consultation session participants.
4. Numerous informal discussion sessions were held between HHS officials and Tribal representatives.
5. Follow-up sessions to further discuss issues of concern to Tribal leaders were scheduled.
6. Visits to reservations by Federal officials were scheduled.
7. MMA training sessions on reservations for appropriate service providers were scheduled.
8. Increased involvement of state officials with Tribal leaders was fostered.
9. Invitations to Regional Director to visit reservations were extended and accepted.
10. Commitments to assist with the FY06 consultation session were made by an IHS area office and South Dakota Tribes.
11. For the first time, reports were made by state officials regarding action they have taken to work with and support Tribes in their state.

DIVISION OUTCOMES AND ACCOMPLISHMENTS

Administration for Children and Families (ACF)

Administration for Native Americans (ANA) published an annual Notice of Public Comment announcement in the *Federal Register* on interpretive rules, policy, or process changes for upcoming fiscal year in accordance with Section 814 of the Native American Programs Act of 1974, as amended.

Office of Community Services (OCS): CSBG and LIHEAP Tribal allocation percents (and funding) have been increased for Tribes and Tribal organizations where use of Census 2000 data results in larger allocations for these Tribal grantees.

Administration on Aging (AoA)

There have been changes in reporting policies. First, beginning in 2006, reports will be annual, rather than every six months. Next, the two program reports – the one for the nutrition and supportive program and one for the Native American Caregiver Support Program – have been combined into one report.

Agency for Healthcare Research and Quality (AHRQ)

AHRQ co-led a department-wide effort to develop a Tribal advisory group on health research that will be funded and managed by the Department after Tribal consultation and Tribal nominations for representatives are completed. The effort will be managed by OMH.

AHRQ became a partner in the FY05 NARCH program, a unique health research activity that awards grants to Tribes to undertake health research of importance to them. Tribes manage the research efforts.

Assistant Secretary for Budget, Technology and Finance (ASBTF)

In May 2004, ASBTF and IGA convened a Department-wide budget consultation session as part of the development of HHS' FY06 budget request. During this session, Tribal Leaders told us that funds to cover the rising cost of providing health care and population growth were their top priorities. In February 2005, the Administration submitted an IHS budget to the Congress which included an increase of $80 million for inflation and population growth, the first Administration budget request to include increases for inflation and population in at least a decade. In August 2005, the President signed the FY05 Interior Appropriations Act, including these funds for IHS.

Assistant Secretary for Planning and Evaluation (ASPE)

Increased Access to HHS Programs: ASPE took the lead, in partnership with ASBTF, ANA, and ICNAA in supporting the Barriers Study, which identifies key programmatic and administrative barriers preventing American Indian, Alaska Native and Native American (AI/AN/NA) communities from more fully accessing HHS grant programs for which they are eligible as well as strategies to reduce these barriers. Study findings will be included in a report that will be posted on the ASPE website in 2006.

Data and Research: In October 2005, ASPE began a 14-month study entitled: Data on Health and Well-being of American Indians, Alaska Natives and Native Americans that will compile information on health and human services data sources pertaining to AI/AN/NAs, explore the quality of these data sources, and identify ways to improve the usefulness of these sources. The products of this study will include a catalogue of data sources and an overview paper on data gaps and options for addressing them.

ASPE supports the HHS Data Council's Working Group on Race and Ethnicity. This group has presented an approach to the Council that includes six possible strategies for improving racial and ethnic data. One of these strategies, a HHS minority data website, is currently being developed and will be linked to the HHS Gateway to Statistics website.

ASPE is supporting an in-house study entitled: Obesity and American Indian/Alaska Native Populations that will include information about contributing factors and preventive programs and interventions. This study is being conducted during FY05 to FY06 and will result in an overview paper including a review of the literature and a summary of selected government agency activities in this area.

ASPE has transferred funds to IHS to support A Study on Best Practices in Indian Health Care. This study is an evaluation of the diffusion and use of best practices for cardiovascular disease (CVD) prevention and treatment to be conducted by the Northern Plains Tribal Epidemiology Center and the Alaska Native Epidemiology Center. Reports from these evaluation studies are expected in December 2005 and December 2006 respectively, and the earlier report will include a surveillance system to monitor CDC's CVD guidelines.

ASPE supports the National Committee on Vital and Health Statistics' Subcommittee on Populations activities on racial and ethnic data. Hearings held by this Subcommittee contributed to a report entitled: *Eliminating Health Disparities: Strengthening Data on Race, Ethnicity and Primary Language in the US*.

Health Promotion and Disease Prevention: ASPE initiated a plan for a U.S./Mexico Indigenous People's Roundtable that will focus on the causes, prevention and treatment of type 2 diabetes among indigenous peoples to be held in early 2006. Expected outcomes also include issue papers prepared by the U.S. and Mexican delegations and possible follow-up meetings.

Centers for Disease Control and Prevention (CDC)

Priorities 1 and 2: Funding and Related Issues; Increased Access to CDC Programs

CDC Tribal Consultation Policy: CDC and ATSDR are the first of eleven HHS operating divisions to establish consultation procedures that comply with the revised HHS Tribal Consultation Policy. This policy was written in direct response to Tribal leaders' requests to have ongoing and meaningful input into CDC programs and policies that affect AI/AN communities. Through a series of meetings hosted by regional and national Tribal health organizations, CDC went directly to Tribal leaders and asked them how they would like to see CDC conduct consultation. This new policy derives from that input.

The CDC and ATSDR policy outlines the need for, and importance of, coordinating, communicating, and collaborating with Tribal governments on issues that affect AI/ANs. It also calls for the establishment of a standing committee of Tribal leaders, the Tribal Consultation Advisory Committee, to advise the agencies on issues relevant to Tribal consultation and the health threats facing Indian country. The policy describes steps that programs should take toward working effectively with AI/AN communities and organizations. The policy identifies when CDC and ATSDR programs should involve Tribal leaders; outlines specific responsibilities regarding program activities, including mutual participation in setting program and budget priorities; and recognizes the importance and value of enhancing AI/AN access to agency programs.

A closer partnership between ATSDR and the Tribes was established, which is critical as we move through the development of public health assessment and related research and education activities. ATSDR has addressed Tribal concerns about ATSDR-related issues at regional consultation meetings and reaffirmed its commitment to the enhancement of the Tribal Environmental Health Education Program (TEHEP). ATSDR has explained funding reductions and redistribution of resources, discussed issues related to the sharing of Tribal sensitive data with ATSDR, and future Tribal public health assessment activities at the site.

With assistance from the National Indian Health Board, CDC and ATSDR will begin implementation immediately by educating and informing both internal program staff and external AI/AN stakeholders about the policy.

Tribal Access to CDC Programs and CDC AI/AN Resource Allocations: CDC's new Tribal Consultation Policy and new procedures implemented by CDC's Procurement and Grants Office (PGO) assure Tribal eligibility for CDC program announcements. In FY05, CDC funded 66 cooperative agreements to 51 Tribal partners (Tribal governments, health boards/coalitions, Tribal organizations, Alaska Native health corporations, urban Indian health centers, and Tribal colleges) across 19 states and the District of Columbia. Total funds allocated through competitively awarded grants and cooperative agreements exceeded $22.5 million. Compared to FY 04, although total funding in this category decreased by about $2 million, the number of awardees increased from 42 to 51 (21 percent increase) and the total number of awards increased from 58 to 66 (14 percent increase).

In addition to grants and cooperative agreements awarded to Tribal partners, CDC allocated more than $9 million through grants and cooperative agreements awarded to state health departments and academic institutions for programs focusing on AI/AN public health issues. The remainder of CDC's AI/AN portfolio falls into three categories: 1) intramural resources (about $6.5M), 2) Federal intra-agency agreements (about $2.5M), and 3) indirect allocations ($28.4M). The majority of the indirect category is resources devoted to immunizing AI/AN children through the Vaccines for Children (VFC) program. CDC estimates its total FY05 resource allocation for AI/AN programs to be approximately $69 million, 33 percent of which goes directly to Tribal partners and 87 percent overall is expended outside HHS.

Priority #3: Health Promotion and Disease Prevention

Infectious Diseases in Alaska Natives: Documented a 90 percent decrease in invasive pneumococcal disease among Alaska Native infants and children after introduction of pneumococcal conjugate vaccine. This has eliminated the longstanding health disparity for vaccine-type disease among Alaska Native children. Ongoing surveillance has established that use of this vaccine has resulted in a decrease in antimicrobial resistant pneumococcal infections and an indirect effect of decreased pneumococcal disease in adults resulting from decreased transmission of pneumococci.

Diabetes: The National Diabetes Education Program (NDEP), a joint initiative between CDC and NIH, has created an extensive partnership network to mobilize public and private sector organizations to work with the NDEP to improve the way diabetes is treated.

Cancer: In FY05, the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) funded 13 Tribal governments and organizations. NBCCEDP has helped to increase mammography use by women aged 50 years and older by 20 percent since the program's inception in 1991. NBCCEDP targets low-income women with little or no health insurance and has helped reduce disparities in screening for women from racial and ethnic minorities. Approximately 50 percent of screenings provided by the program were to women from racial or ethnic minority groups. Of that 50 percent, approximately 6.8 percent are AI/AN women.

The National Comprehensive Cancer Control Program (NCCCP) is a collaborative process through which a community and its partners pool resources to promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer. These efforts will contribute to reducing cancer risk, detecting cancers earlier, improving treatments, and enhancing survivorship and quality of life for cancer patients. In FY05, CDC expanded NCCCP adding two new programs, one of which was the Aberdeen Area Tribal Chairmen's Health Board. With $15 million this year, CDC supported 59 comprehensive cancer control capacity building programs across the United States, including six Tribes and Tribal organizations.

Tobacco: For the past five years OSH has funded seven Tribal Support Centers to build capacity and infrastructure in Indian Country to prevent and control the non-traditional uses of tobacco among American Indians and Alaskan Natives. The Support Centers provide technical assistance and consultation directly to Tribes and organizations that work with Tribes about culturally competent approaches to working with AI/ANs as they develop educational messages and policies to reduce tobacco use among native people.

Priority 5: Emergency Preparedness

In FY05, $3,800,000 of states' cooperative agreement funds were disseminated to Tribal nations, IHS, and Tribal organizations in the form of grants, contracts, and dedicated staff. Of this amount, $1.1 million went to benefit Tribal nations, associated organizations, and other response partners through activities such as the hiring of liaisons, resources to support Tribal planning, and training and education.

Priority 6: Data and Research

International Indigenous Health Measurement: NCHS, with NCCDPHP participation, organized an international collaboration to focus on improving the measurement of health status in Indigenous populations in the U.S., Canada, Australia, and New Zealand. This group, known as the International Group for Indigenous Health Measurement, planned to hold its first meeting in Vancouver, Canada in October 2005. The group includes government representatives, researchers and representatives of Indigenous organizations from the four countries. Because of the focus on measurement of health status, the group made a special effort to include representatives from the health statistics organizations of each member country.

Atlas of Heart Disease and Stroke Among American Indians and Alaska Natives 2005 was published in May 2005. It was released at the Prevention of Cardiovascular Disease & Diabetes Among American Indians and Alaska Natives 2005 Conference (May 16-19, Denver Colorado). This atlas is the first to focus on the geographic disparities of heart disease and stroke mortality and risk factors for a specific racial/ethnic group. Available at http://www.cdc.gov/cvh/library/aian_atlas/introduction.htm.

Health Characteristics of the American Indian and Alaska Native Adult Population: United States, 1999–2003 is a report that compares national estimates for selected health status indicators, health behaviors, healthcare utilization, and health conditions of American Indians and Alaska Natives with those of White, Black, and Asian adults 18 years of age and over. Available at http://www.cdc.gov/nchs/data/ad/ad356.pdf.

HIV/AIDS Fact Sheet. HIV/AIDS among American Indians and Alaska Natives. 2005. Available at http://www.cdc.gov/hiv/pubs/Facts/Indian.htm.

Other Notable Publications

Espey, D, Paisano, R, Cobb, N. Regional patterns and trends in cancer mortality among American Indians and Alaska Natives, 1990 – 2001. *Cancer.* 2005; 103(5):1045-53.

Schneider, E. Tuberculosis Among American Indians and Alaska Natives in the United States, 1993 – 2002. *Am J Public Health.* 2005; 95:873-880.

Demma, LJ, Traeger, MS, Nicholson WL, et al. Rocky mountain spotted fever from an unexpected tick vector in Arizona. *N Engl J Med.* 2005; 353:587-94.

Centers for Medicare and Medicaid Services (CMS)

Medicare Part D Prescription Drug Coverage: CMS is working with the TTAG Outreach & Education Committee, IHS, and SSA to provide materials to educate beneficiaries about their options with regard to the new Medicare drug coverage. CMS provided $250K to IHS through an intra-agency agreement to conduct trainings for IHS and Tribal providers and staff. Between April and June 2005, IHS, CMS and SSA staff provided awareness trainings in each of the 12 IHS areas for Indian health providers. A second set of trainings was held for the 12 IHS areas during fall 2005 for key I/T/U staff. To help educate the Tribal community at large, CMS convened a Tribal Open Door Forum in July 2005 during which the 218 participants obtained updated information on implementation activities for the new program. Awareness trainings were held in June 2005 in Anchorage and Seattle, and a September 2005 session was held that focused on patient education, and enrollment. CMS has also developed a Campaign-within-a-Campaign team that maintains focus on AI/AN education and issues impacting Part D. CMS created a listserv to broadly disseminate information on events, open door forums, new tools, updated information, etc. To ensure ample I/T/U provider participation, both IHS and the TTAG developed contract addenda to help IHS and Tribal pharmacies have an equal chance to be among the providers in prescription drug plan networks. Among other things, the addenda helped to ensure that I/T/U providers do not have to give up their sovereignty in order to participate in the prescription drug plans. CMS has also addressed the TTAG's concerns that Tribal providers receive equitable reimbursement—the Medicaid payment rates instead of Medicare rates—for the dual eligible beneficiaries and those involving notification of how Tribes will be notified of what plans their beneficiaries have been auto-assigned. CMS continues to work with the TTAG's Outreach & Education Subcommittee, IHS, and SSA to develop and provide materials to educate AI/AN beneficiaries about their options under the new Medicare drug coverage and to address implementation issues as they arise in Indian Country.

Appointment of a Tribal member to Medicaid Commission under Public Law 92-463: On July 8, Secretary Leavitt announced that Valerie Davidson would be the AI/AN representative to the Commission. She serves as a non-voting member.

Policy Guidance for Medicaid Administrative Matching (MAM) Program: On October 18, CMS released a Dear State Medicaid Director letter describing CMS' policy regarding the conditions under which Tribal organizations can certify expenditures as the non-Federal share of Medicaid expenditures for Medicaid administrative services directly provided by such entities. However, the letter stated that Tribes must use funds other than those included in the Indian Self Determination and Education Assistance Act (ISDEAA, P.L. 93-638) to perform Medicaid administrative activities under agreements with State

Medicaid agencies. Restricting the use of ISDEAA funds is in conflict with previous guidance and interpretations. CMS, IHS, and OGC staff is currently working to address this new concern.

Medicare Like Rates: Section 506 of the Medicare Modernization Act: The regulation is currently in the review process. Although the MMA specified implementation by December 2004, issues identified by IHS regarding the language were not resolved until September 2005. OMB has 90 days to review the final language and a 60-day comment period follows that. While the TTAG continues to push for expedited review and publication of the regulation, they were advised that OMB must consider impact on the private sector and the public must be allowed to comment. The rates will be effective on the date of publication; IHS will review comments and finalize clearance.

Equitable Relief: The TTAG requested to review a draft CMS decision memo. The TTAG established an Equitable Relief subcommittee which convened on March 9 and have requested more time to thoroughly explore all options potentially available. Additionally, IHS will work with TTAG and appropriate CMS and SSA staff to discuss implementation of this new equitable relief policy. Tribes may pay Part B premiums on behalf of their members by establishing a formal Group Payer Agreement with CMS.

CMS Consultation Policy: The TTAG established a Tribal consultation policy Subcommittee that developed a proposed policy for CMS review. CMS has made changes and the TTAG will be conducting consultations on the plan in early 2006.

CMS Strategic Plan: The TTAG has developed a five-year draft plan (through 2010) that is currently undergoing Tribal consultation. Dr. McClellan has agreed to have CMS senior staff meet with the TTAG during their February 2006 in-person meeting to discuss the proposed plan.

Health Resources and Services Administration (HRSA)

Health Professions Recruitment: Despite the loss of several key team members, the Bureau of Health Professions (BHPr) and the IHS continue to collaborate with one another. For example, BHPr increased the number of National Health Service Corps (NHSC) clinicians serving in I/T/U sites. The team is proud to report that the NHSC currently has 65 clinicians working at I/T/U sites, an increase of 23 clinicians since May 2005. More impressive is the number of loan repayors approved to work at I/T/U sites due to this collaboration. For example, in May 2005 the NHSC had no loan repayors working in I/T/U sites. Today, the NHSC has a preliminary count of eight clinicians working at I/T/U sites. The increase in the number of clinicians is directly related to the recruitment efforts of both the IHS staff and the NHSC.

The Shortage Designation Branch in BHPr has been working to have all Tribal facilities identified as automatically designated Health Professional Shortage Area (HPSA) facilities. The process is similar to one already completed for the Federal IHS facilities. The listings of I/T/U sites have been included on the HPSA website under Automatic HPSA listings, are being added to the data base, and will then be posted to the HPSA query page. These designations allow facilities to recruit through the NHSC. A brief action plan was prepared to address the issue of gathering data for HPSA scores since scores are used by the NHSC to prioritize placement opportunities. The branch is prepared to work with representatives of Tribal organizations and facilities to identify additional data which might improve the scores. More details are available on the HPSA website http://bhpr.hrsa.gov/shortage under Automatic HPSA scoring.

Emergency Preparedness: Five Emergency Medical Services for Children (EMSC) State Partnership grant initiatives aimed at AI/AN populations initiated in Alaska, Hawaii, Oregon, North Dakota, and South Dakota. Each State receives a partnership grant of $115,000 of which ten percent is spent on AI/AN populations. Interagency Agreement between HRSA's EMSC Program and the IHS Division of

Environmental Health Services for $250,000 in FY05. The focus of this agreement is to provide for collaborative activities between EMSC and IHS and increase access to EMSC resources for underserved populations, including AI/AN populations. A large portion of these funds will go toward pediatric specific training for pre-hospital providers within Tribal health and IHS.

Health Care Access: HRSA continues to actively work to ensure that AI/ANs have access to health care services and resources. In FY05, meetings took place to begin development of an implementation plan for the HIV/AIDS Workgroup. A mailing list or listserv and planning for a TA call for grantees and providers which service AI/AN was discussed as tools to communicate with and notify Tribal organizations, Tribal leaders, IHS, and urban Indian centers of CARE Act resources. In addition, the HIV/AIDS Workgroup recently completed a TA needs assessment of CARE Act grantees that provide services to AI/AN. The assessment identified confidentiality, trust, and stigma; coordination among agencies; transportation and socioeconomic status; cultural competency; and co-morbidities as barriers to providing HIV primary care and support services.

HRSA offered competitive grants to AIDS Education and Training Centers (AETC) programs to provide training initiatives for AI/AN health care providers. The funding allows HRSA to provide training to all members of the health care team that are supporting HIV diagnosis, referral, and treatment. In addition to traditional education and training activities, AETC grantees can provide support for HIV clinical preceptorships and on-site HIV clinical capacity building assistance for AI/AN health care providers.

The SPNS is an intervention demonstration and evaluation project that integrates substance abuse and mental health services with HIV care for AI/AN. The target population is identified as HIV positive or at risk for HIV infection or the co-morbidities of substance abuse (including alcohol), sexually transmitted infections (STIs), and/or mental illness. The desired outcomes of the model interventions are increasing: number of AI/AN substance/alcohol abusers at risk for HIV who know their HIV status; number of multiple-diagnosed AI/AN who are receiving appropriate and consistent health care for HIV infection, STIs, substance abuse, and mental illness; number of multiply diagnosed AI/AN who are undertaking actions to prevent further spreading of HIV; and adherence of multiply diagnosed AI/AN to anti-retroviral therapies and other prescribed medical treatments for STIs, substance abuse, and/or mental illness.

Health Promotion and Disease Prevention: Thirteen health center teams of Tribal entities and Urban Indian grantees are participating in diabetes, cardiovascular, and depression collaboratives. As a result of their participation, the health outcomes of AI/ANs have improved and there is evidence that these improvements are being sustained over time.

Staff from the Bureau of Primary Health Care (BPHC), Division of Policy and Development, participated in numerous technical assistance sessions and training activities that were attended by Tribal organizations, including training events sponsored by the national and State organizations; national pre-application conference calls for all of the announced competitive opportunities to provide technical assistance on the requirements of the program and expectations for successful applicants; and responding to numerous requests for additional information on BPHC programs, requirements and expectations. These staff also conducted a site visit to Eastern Shoshone and Northern Arapahoe Tribes on the Wind River Reservation in Wyoming to discuss the requirements for the Consolidated Health Center Program.

BPHC staff provided information regarding reimbursement policy interpretation for Tribes with Section 330 funding and similarly clarified licensure requirements for providers. During FY05, BPHC staff worked jointly with CMS and IHS to respond to Tribal questions initially raised at this meeting.

Other Accomplishments: HRSA received two Congressional earmarks to promote mental health among Native American communities.

Food and Drug Administration (FDA)

Southeast Region met with representatives of the Poarch Creek Indian Health Clinic. The Public Affairs Specialists provided information on FDA's education and outreach initiatives such as Take Time to Care Education Campaign on safe use of medicines, and food safety.

FDA continued to work with the Bureau of Indian Affairs, U.S. Department of the Interior, the Environmental Protection Agency, and the Department of Justice to teach a pilot environmental health workshop at four Tribal colleges and Universities – Southwestern Indian Polytechnic Institute, Little Big Horn College, United Tribes Technical College and Cankdeska Cikana Community College.

FDA continued to implement an environmental health workshop in collaboration with the Environmental Protection Agency, Global Village Engineer and Harvard Universities School of Public Health. The workshop provides training for Tribes through Tribal colleges and universities to increase Tribal knowledge about environmental safety. FDA also provided environmental health training for the Winnebago Reservation in Nebraska. The Tribes unresolved environmental health issue is lead. The participants will gain the knowledge and tools to resolve the problem.

Central Region continued partnerships on seafood safety with various Tribes – Keweenaw Bay Indian Community, Bad River Band of the Lake Superior Tribe of Chippewa, and Red Cliff Band of Chippewa.

Pacific Region continued to work with the Hoopa Valley Tribe to confirm a partnership agreement on low-acid canning processes and regulatory compliance.

Pacific Region Retail Food Specialist continued to work with the Crow Reservation, Montana, in the Voluntary National Retail Program. The specialists provided food safety management courses, information on the Food Code. Regional Shellfish Specialists provided training and technical support to Tribes in western Washington on shellfish harvesting and handling practices.

FDA worked with the Department of Veterans Affairs, the Shinnecock Reservation and elders from other Tribes to set up the Native American Indian Health Council. FDA and the Department of Veterans Affairs meet monthly with elders from various Nations in New York State.

FDA's Northeast Region Retail (NER) Food Specialists continued to work with the Mohegan Tribal Health Department in Connecticut in the Voluntary National Retail Program Standards. The NER is helping the Tribe with a self-assessment program. Food Specialists continue to work with the Tribe in the standardization of their staff in the application of the Model Food Code. Food Specialists continue to provide technical assistance and training when requested by the Mashantucket Pequot Tribe.

Indian Health Service (IHS)

Policy adopted on Provision of Direct Care Health Services to Ineligible Individuals Under Section 813(b)(1)(A) of the Indian Health Care Improvement Act.

Office for Civil Rights (OCR)

OCR financed three American Indian student interns from WINS, a program sponsored by American University for Native students to obtain work experience. OCR also hired an additional American Indian student intern from the University of Denver. As a result of their internships with OCR, the students indicated that they had gained valuable insight into, and perspective of, the operations of health care and social service delivery systems; prohibited discriminatory actions in HHS-financed health care and social service programs; and requirements of the HIPAA Privacy Rule. This knowledge, they stated, will be used to help their families and communities obtain better access to the systems. The WINS organization also expressed appreciation for OCR's support of the program.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Suicide Prevention Efforts: SAMHSA assists Tribes in a number of ways in the context of efforts to prevent suicide, particularly youth suicide. This is crucially important, and is closely linked to the Tribal priority of health promotion and disease prevention. American Indians and Alaska Natives have the highest rate of suicide among all racial/ethnic groups in the United States, with a rate 2.5 times higher than the national average. More than half of all persons who commit suicide in Indian communities have never been seen by mental health providers, despite the fact that depression, as well as substance abuse, are the most common risk factors for completed suicides.

SAMHSA's Tribal-focused *Circles of Care* program emphasizes that components be built into systems of care that address the resiliency needed in order to prevent youth suicide. Also, the Agency's *Youth Violence Prevention Program* promotes the creation and expansion of collaborations to prevent youth violence, suicide, substance abuse, and other behavioral problems. A number of Tribes have been grantees under this program. In FY05, however, suicide crises on reservations appeared to increase more than ever. During the year, as referred to in Section 1 under "Emergency Response," SAMHSA assisted two Tribes in particular. In February and April 2005, respectively, CMHS staff and the Director of the One Sky Center visited the Standing Rock Sioux Tribe and the Red Lake Band of Chippewa Indians. Both Tribes were trying to cope with the suicide clusters occurring on their reservations. SAMHSA and One Sky collaborated closely with IHS personnel during the visits, providing support that included TA related to building infrastructure and applying for SAMHSA Emergency Response Grants (SERGs). Both Tribes have received SERG funding. Following the initial visit to Standing Rock, One Sky submitted to SAMHSA a recommended strategic plan with detailed objectives for addressing the situation there.

An ongoing effort, stemming from a visit to Alaska made by IGA, the Deputy Secretary and the SAMHSA Administrator (among others), entails work that SAMHSA is planning in partnership with IHS to address the high rates of suicide in the Alaskan villages of Savoonga and Gambell. This effort is described in Section 1.

Increased Access to SAMHSA Grants: As mentioned in the Background section on page 1, SAMHSA's Administrator expanded the Tribal eligibility policy in relation to the Agency's discretionary grants. Beginning in FY05, Tribal entities became eligible for all grants for which States are eligible unless there is a compelling reason to the contrary, and that reason would need to be approved by the Administrator. The narrative under Section 1, in relation to increasing Tribal access to grants, demonstrates a wide variety of TA activity and grant awards directed to Tribes and Tribal organizations. SAMHSA considers this work to be a major accomplishment in its ongoing efforts to help Tribal entities increase access to the Agency's grants. Reflective of the outcome of these efforts is the increase in targeted and discretionary funding that went to AI/AN communities in FY05 (see below). Additionally, SAMHSA has participated on the Department workgroup that is helping ASPE develop and finalize the “Barriers Study,” which will be of significant benefit to all HHS Divisions in overcoming the obstacles that prevent maximum access by Tribal entities to the Department’s grant programs.

Increased Funding to Tribes: SAMHSA’s targeted and discretionary funding that went to AI/AN communities increased from $41,363,000 in FY04 to $45,929,000 in FY05, an 11 percent increase. For details, see the Attachment.

Expanding Access to HHS Programs: By means of a SAMHSA-conceptualized workshop at a major Tribal summit, AI/AN awareness of the HHS/OS policy on Tribal Consultation was increased, with specific attention to States’ responsibilities to Tribes when States receive HHS funding.

SAMHSA participated on the Tribal/HHS workgroup that developed the Department’s final Tribal Consultation Policy. A major purpose of the policy is to facilitate an increase in the access of Tribes and Tribal organizations to HHS grant programs. For the June 2005 IHS/SAMHSA Behavioral Health Summit in San Diego, SAMHSA conceptualized and helped to organize a workshop focusing in large part on the aspect of the policy related to criteria on when States are responsible for consulting with Tribes. In addition to Tribal and State representatives on the workshop panel, SAMHSA invited staff from IGA to present on the Department’s policy.

The decision to hold this workshop was based upon the frequency of comments from Tribal leaders and members about “the unlevel playing field” whereby Tribes must often compete with States for discretionary grant funding. One step that SAMHSA made to address this issue stemmed specifically from Tribal feedback given to SAMHSA during the FY05 Region I Tribal consultation. A Tribal leader referred to the unfairness of small Tribes having to compete not only against very large Tribes but also against States. SAMHSA subsequently established an Agency-wide policy of accepting grant applications from Tribal coalitions, not just individual Tribes and Tribal organizations.

The situation remains, however, that States tend to dominate the receipt of grant awards when they are eligible entities for HHS programs. Therefore, the San Diego workshop was held to address this issue. The workshop attendees asked questions and made comments demonstrating strong interest in and keen awareness of the section’s importance. The key section of the OS policy follows:

> When States are authorized to administer HHS programs, services, and funding for the benefit of Indian Tribes and AI/AN’s, IGA will collaborate with Divisions to assist States in developing mechanisms for consultation with Indian Tribes before taking any actions that have substantial direct affect on Indian Tribes. HHS will recommend the development of State plans for Tribal consultation. States will receive HHS technical assistance in developing these plans.

Section 4

Tribal Assessments of Consultation Efforts

SECTION 4: TRIBAL ASSESSMENTS OF CONSULTATION EFFORTS

The revised HHS Tribal consultation policy calls for each agency to solicit feedback from Tribes on HHS Tribal consultation sessions and efforts. The policy requires that this information be included in the Annual Tribal Consultation Report. Since 2005 is the first year that the new policy was implemented, consultation efforts were not monitored for reporting requirements. Thus, this section contains evaluation feedback reported from Tribal representatives who participated in 2005 consultation sessions. In 2006, additional focus will be placed on asking the Tribes to evaluate and share their impressions of HHS consultation efforts.

REGIONAL TRIBAL CONSULTATION SESSIONS FEEDBACK

The evaluations received from participants reflected overall satisfaction with the consultation sessions. Tribal representatives were particularly pleased with the opportunity to interact and present their concerns and suggestions with so many high level Federal and state representatives. Similarly, they found the opportunity to meet with other Tribal leaders helpful. The Tribes were also appreciative of the information provided on available grant funding opportunities, as well as the updates on state and Federal legislation affecting the Tribes, particularly the Medicare Modernization Act and drug benefit.

Tribal representatives provided additional feedback on what changes they would like to be made for future consultation sessions. For example, Tribes at the Region II consultation requested additional time to address their concerns and to interact with governmental officials; Region II will look at extending next year’s session. Also, at the request of the Tribes, the Region will invite additional Federal agencies, especially grant funding agencies and attempt to provide additional sessions on legislative/regulatory updates. Tribal representatives in attendance at the Region VII consultation requested more opportunity for Tribal dialogue amongst the Tribes. Additionally, they recommended that the Federal updates be more brief and focused on Tribal priorities instead of Federal priorities. Requests from the Region VIII consultation included: greater opportunity for informal discussion between Tribal leaders and HHS officials; less time devoted to formal HHS presentations; increased time for Tribal presentations; greater emphasis by HHS regional officials on presenting program information of direct interest to Tribal governments; greater effort to involve Tribal leaders in the consultation planning process; seek greater input from Tribal leaders on items to be discussed; and increased efforts to recognize Tribal leaders.

In addition, the Tribes want a mechanism to be established to keep them informed of new legislation and regulations on a continuing basis, rather than only once a year at consultation sessions. The Tribes would like more financial support to address health conditions such as obesity, diabetes and cancer. The Tribes would like authorization for their clinics to bill Medicaid for services provided to non-Native Americans.

In conclusion, it is hoped that follow-up and changes will occur to assist Tribes with the issues expressed at the consultations.

HHS ANNUAL TRIBAL BUDGET CONSULTATION SESSION FEEDBACK

HHS participants and Tribal Leaders agreed on the following suggestions for the next Annual Tribal Budget Consultation Session.

Regarding the session format and agenda, a suggestion was to combine the policy and budget discussion, so that agencies don't have to show up for similar discussions on two days and the days might not feel so pressed for time. Another suggestion was to organize he discussion around issues rather than around Federal agencies, and then invite all the Federal agencies who might be involved in addressing that issue to respond. Representatives requested that ICNAA members have information tables at the end or beginning of the consultation day to answer specific division questions or issues one-on-one and distribute information on funding opportunities.

Regarding presentations, it was mentioned that more time is needed for both HHS and Tribal presentations to ensure a quality dialogue, even if this means fewer speakers or a full two-day session. Tribes desire the opportunity for senior HHS staff to engage in a full dialogue with the Tribal leaders. It would be preferable if Federal presenters would respond specifically to the Tribes' concerns and share any progress that has been made as a result of consultation.

Regarding accessibility, it was recommended that HHS take advantage of video-conference capabilities at IGA regional offices or other satellite sites to allow elected Tribal Leaders to participate at these sites if travel to the Washington, DC session is not possible; this would also provide an opportunity for more interaction between Regional offices and Tribes.

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D: HHS FUNDING FOR TRIBES

Table 1: HHS Funding for AI/AN Targeted Programs

Table 1 includes funding for programs that are earmarked exclusively for American Indians and Alaska Natives.

Table 1: HHS Funding for American Indian and Alaska Native Targeted Programs

(Dollars in millions)

			FY07 P.B.		
				+/- FY06	
Program	**FY05**	**FY06**	**Total**	**($)**	**(%)**
Indian Health Service: /1....................................	$3,812.6	$3,879.4	$4,003.9	+$124.5	+3.2%
Administration For Children and Families (ACF):			-	-	
Head Start...	$186.9	$185.4	$185.4	--	--
Administration for Native Americans.............	44.8	44.3	44.3	--	--
Low Income Home Energy Assistance:...........	22.0	21.7	21.1	-0.6	-2.6%
Child Care Programs.......................................	96.0	99.6	99.6	--	--
Family Violence..	12.6	12.5	12.5	--	--
Community Services Block Grant /2...............	4.9	4.6	--	-4.6	-100.0%
Community-Based Child Abuse Prevention.....	0.4	0.4	0.4	--	--
Promoting Safe and Stable Families...............	5.0	4.8	5.2	+0.4	+8.3%
Tribal TANF..	141.0	159.1	159.1	--	--
Tribal Work Program.......................................	7.6	7.6	7.6	--	--
Tribal Child Support /3....................................	12.5	17.0	30.0	+13.0	+76.5%
Tribal Foster Care..	--	--	30.0	+30.0	--
Child Welfare Services (IV-B)........................	5.5	5.5	5.5	--	--
Subtotal, ACF...	$539.2	$562.4	$600.6	+$38.3	+6.8%
Administration on Aging:					
Grants to Tribes...	$32.7	$32.4	$32.4	--	--
Centers For Disease Control and Prevention:					
Preventive Health Block Grant /2....................	$0.1	$0.1	--	-$0.1	-100.0%
Substance Abuse & Mental Health Services Administration:					
Grants to Tribes...	$3.5	$3.5	$6.5	+$3.0	+84.1%
HHS TOTAL..	**$4,388.2**	**$4,477.8**	**$4,643.4**	**+$165.6**	**+3.7%**

/1 Includes insurance collections, rental of quarters and mandatory diabetes funding.
/2 The FY06 budget does not include funding for this program.
/3 Assumes additional Tribes will run their Child Support programs in FY07.

Table 2: HHS Funding For AI/AN Targeted and Discretionary Funding

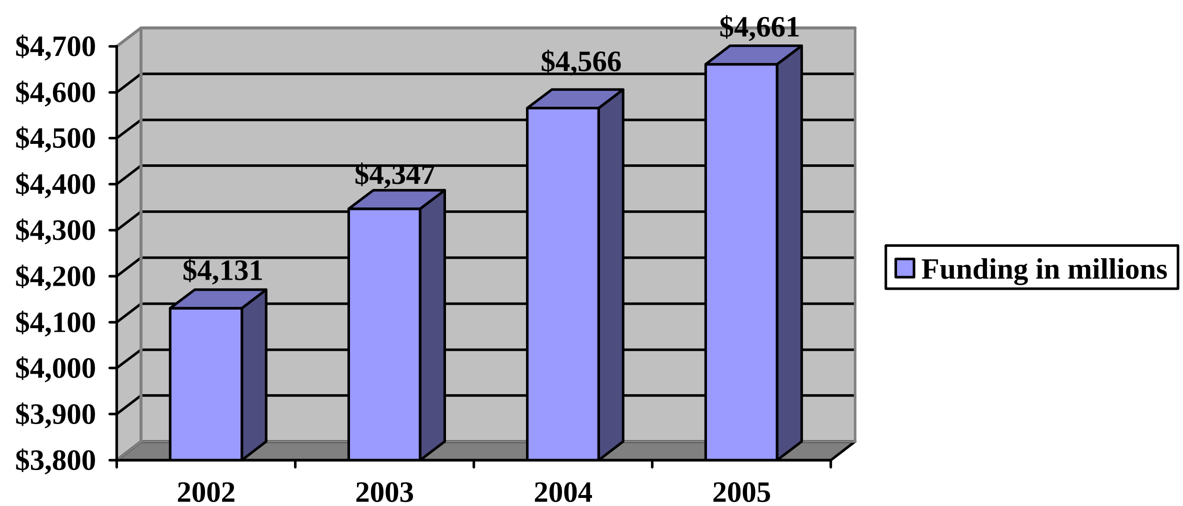
Table 2 includes earmarked funds as well as discretionary funding or funding provided competitively to Tribes or for the benefit of Tribes.

These data do not include HHS resources provided as a benefit to AI/AN individuals such as Medicare, Medicaid, and Temporary Assistance for Needy Families (TANF) provided through state administered TANF programs.

HHS Tribal Resource Trends – FY 2004 and FY 2005

	FY04	FY05	Change	Percent Change
IHS	$3,706,133,000	$3,774,095,000	$67,962,000	1.83%
ACF	$527,313,155	$529,807,299	$2,494,144	0.47%
NIH	$133,917,000	$140,091,000	$6,174,000	4.61%
SAMHSA	$41,363,000	$45,929,000	$4,566,000	11.04%
AoA	$33,683,427	$34,591,000	$907,573	2.69%
CDC	$75,281,951	$69,118,917	-$6,163,034	-8.19%
HRSA	$38,406,776	$59,693,609	21,286,833	55.42%
ASH	$3,772,188	$2,634,164	-1,138,024	-30.17%
AHRQ	$4,681,581	$4,065,039	-$616,542	-13.17%
CMS	$957,170	$893,000	-$64,170	-6.70%
TOTAL	**$4,565,509,248**	**$4,660,918,028**	**$95,408,780**	**2.09%**

Figure 1: HHS Tribal Resource Trends – FY 2002 to FY 2005



E: FEDERAL-STATE-TRIBAL HUMAN SERVICES COLLABORATION FINAL REPORT

Final Report to the U.S. Department of Health and Human Services on the HHS IGA/APHSA/NCAI Initiative
January 2006

<u>Executive Summary</u>

In October 2003, the National Congress of American Indians (NCAI), the American Public Human Services Association (APHSA), and the Office of Intergovernmental Affairs (IGA) of the U.S. Department of Health and Human Services (HHS) agreed to come together in partnership to examine human service policy and practice as it relates to Native children and families both on and off of Indian lands. Broadly, the goals of the partnership were to:

- Increase collaboration between federal, state, and tribal governments on the implementation of human service programs in Indian Country for the purpose of sharing information and innovative ideas, and identifying best practices on a national level;
- Increase collaboration between federal, state, and tribal governments to discuss and better inform federal policy proposals and decisions;
- Increase federal/state/tribal understanding of tensions in specific human service policies and programs;
- Develop strategies to locally improve federal/state/tribal communication and coordination on issues that affect Native families and children;
- Increase tribal participation in the development of policies and plans of state-administered human service programs;
- Expand opportunities for integration for programs that serve tribes at the local level by developing demonstration options and waiver opportunities with incentives that encourage state and local governments to participate; and
- Identify tribal experts with expertise in human services issues who can provide technical assistance to HHS regional staff in support of their tribal coordination, communication and consultation sessions.

Over the course of the two-year initiative, HHS convened a workgroup comprised of tribal and state human service administrators and key administration staff (with broad expertise in multiple human service issues areas) as a vehicle to facilitate collaboration between HHS, APHSA, and NCAI. With direction and feedback from the Workgroup, the Initiative culminated in December 2005 with a number of accomplishments, including:

- The convening of an initial planning meeting, multiple human service policy academies, and conference calls about substantive human service program implementation and policy issues;
- The development of reports, meeting summaries, and conference call notes that document the work of the Initiative as well as address particular human service program areas;
- The development of an Initiative website (hosted by APHSA) that includes new resources, such a searchable database of models of intergovernmental coordination on human service issues and a comprehensive resource guide that identifies federal, state, and tribal contacts for various human service programs; and
- The broad sharing of the work of this Initiative through many project staff presentations, including presentations at 20 HHS national consultation sessions, 3 ACF consultation sessions, 4 national budget sessions, and 16 regional sessions.

Background

In October 2003, the National Congress of American Indians (NCAI), the American Public Human Services Association (APHSA), and the Office of Intergovernmental Affairs (IGA) of the U.S. Department of Health and Human Services agreed to come together in partnership to examine human service policy and practice as it relates to Native children and families both on and off of Indian lands. Because tribes, counties, states, and the federal government all play a role in the delivery of social services to Native populations, it is only logical that these governmental entities come together to discuss significant issues in the delivery of services between and within governments. Moreover, it has been noted in HHS Regional Consultation Sessions with tribal and state governments, as well as in numerous other places, that the sharing of information, best practices, and promising approaches and the coordination between these entities in shaping federal policy can be improved.

IGA/APHSA/NCAI undertook the "Federal-State-Tribal Human Services Partnership" Initiative ["Initiative"] as a first step toward improving cooperation. This collaboration lent itself to new opportunities to share best practices and approaches and to improve coordination and communication between the federal, state and tribal entities responsible for providing human services. After a highly successful first year, the Initiative was refunded by the Administration for Native Americans (ANA). In the second year of project work, efforts focused on developing tools that would institutionalize the project by facilitating the ongoing sharing of information and best practices through a project website and web-based resource guide.

Participating Organizations

The three partnering organizations were identified as uniquely qualified to address the intergovernmental collaboration and coordination of human service programs in Indian Country as described below.

- *Office of Intergovernmental Affairs (IGA), Department of Health and Human Services:* This office serves as the Secretary of Human Service's conduit on human services policy matters concerning state, tribal and local governments, and their respective organizations. IGA is responsible for ensuring discussions occur between state and tribal partners as the lead office for Secretarial consultation responsibilities. It also is well positioned to bring colleagues of the department to the initiative such as staff of the Administration on Children and Families that administers a majority of human service programs. Also, HHS Regional Directors (RD) system will have the opportunity to play an integral part to the process. They will have access to the products produced during the initiative, as well as provide technical assistance as requested.

- *The American Public Human Services Association (APSHA):* As a membership association, APHSA can draw from its members that include all state and many territorial human service agencies, more than 100 local agencies, and several thousand individuals who work in or otherwise have an interest in human service programs. Our membership is not only the state commissioners and secretaries of human services but also the directors of various programs such as Child Care, Child Welfare, Child Support, Food Stamps, Information Systems, TANF, and Medicaid. Many of these listed programs have organized into APHSA affiliate organizations, which hold regular meetings on their specific areas of expertise.

- *The National Congress of American Indians (NCAI):* As the oldest, largest, and most representative national organization addressing the interests of American Indian/Alaska Native tribal governments, NCAI works with elected tribal leadership and human service program directors from the 562 federally-recognized tribes to address a whole range of human service policy and programmatic issues. The umbrella function and structure of NCAI also means that various regional tribal organizations and national issue-specific tribal organizations are informed by and coordinated with NCAI's work. NCAI's committee structure also directs particular attention to human service programs through the work of the Human Resources Committee and, more specifically, the Indian Child and Family Welfare Subcommittee.

Goals and Activities of the Partnership

At the outset of the joint initiative, the three organizations set out the following goals:

- Increase collaboration between federal, state, and tribal governments on the implementation of human service program in Indian Country for the purpose of sharing information and innovative ideas, and identifying best practices on a national level.
- Increase collaboration between federal, state, and tribal governments to discuss and better inform federal policy proposals and decisions.
- Increase federal/state/tribal understanding of tensions in specific human service policies and programs.
- Develop strategies to locally improve federal/state/tribal communication and coordination on issues that affect Native families and children.
- Increase tribal participation in the development of policies and plans of state-administered human service programs.
- Expand opportunities for integration for programs that serve tribes at the local level by developing demonstration options and waiver opportunities with incentives that encourage state and local governments to participate.
- Identify tribal experts with expertise in human services issues who can provide technical assistance to HHS regional staff in support of their tribal coordination, communication and consultation sessions.

In the first year of project work, the proposed project activities fell into four primary categories: (a) initial planning meeting; (b) tribal/state/federal human services workgroup; (c) human service academies; and (d) reports/summaries.

- *Initial Planning Meeting*: Convene a joint HHS/APHSA/NCAI planning session where participants will finalize the goals and objectives of the initiative for the year. They will also identify the key human service issues to be addressed in joint policy academies, future meetings of the Advisory Workgroup, various products of the initiative, and possible funding opportunities.

- *Federal/State/Tribal Human Service Workgroup*: As a vehicle to facilitate collaboration between the three entities, a workgroup comprised of tribal and state human service administrators and key administration staff (with broad expertise in multiple human service issues areas) will be formed to guide the process. This group will formulate the specific topics to be covered during the academies and be responsible for soliciting and responding to feedback from the broader communities. A "core group," consisting of representatives from each partner organization was identified to serve as the day-to-day executive committee of the Workgroup. The core group took responsibility for arranging Workgroup conference calls, setting the agenda for these calls and tracking progress on tasks that came out of the calls. The core group also worked to identify and prioritize potential policy topics.

- *Human Service Policy Academies*: One to two-day policy academies will be convened on specific human service program areas where tribal, state, and federal administrators can come together to discuss their respective roles and challenges in providing services to Native children and families.

Communication and coordination barriers and ways to overcome them will be highlighted. Particular attention will be paid to programs that may be in the process of being transitioned from state to tribal administration (e.g., child support). As part of the academies, expert participants will identify opportunities to assist HHS Headquarters and regional staffs that will enhance the ongoing state, tribal, local coordination, communication and consultation sessions.

- *Reports/Summaries*: Various materials and analyses related to the policy academy topics as well as general documents to improve intergovernmental understanding will be produced and disseminated throughout the course of the project. These materials will be made available on NCAI's and APHSA's websites and distributed electronically and in hard copy to participants of various forums.

The HHS Federal/State/Tribal Human Services Workgroup approved the above-listed goals and project activities.

In the second year of project work, two additional activities supplemented ongoing work on the activities established in year one: (a) best practices survey and website; and (b) resource guide.

- *Best Practices Survey and Website:* The three partnering organizations will develop a survey of model practices of intergovernmental coordination and collaboration. Each of the three partners will send out the survey to their respective constituents, asking them to fill out the survey and share any supporting documentation relating to the model practices that they are submitting. All responses will be formatted and made available via the Internet. Model practices will be inputted into a searchable database so that users can search for intergovernmental coordination/collaboration models by geographic area, by program area, or by category of the model (i.e. memorandums of agreement, legislation, contracts, pamphlets, training documents, etc.).

- *Resource Guide:* A comprehensive resource guide that identifies federal, state, and tribal contacts for various human service programs will be developed. This matrix, organized by federal region and by state, will be posted on the Internet to facilitate ongoing updating of information in attempt to keep the guide current.

Project Accomplishments

Overall, the Workgroup was extremely successful in identifying significant policy topics of mutual interest and bringing joint tribal, state and federal attention to them. Notably, the project:

- Raised awareness of the need for and value of intergovernmental collaboration across a broad range of human service issues and the willingness of representative from all three governments to do so;
- Brought new stakeholders into the conversation (including new departments/programs/staff within the three collaborating organizations); and
- Laid the groundwork for regular, ongoing and formal three-way governmental collaboration.

Specifically, over the last two years, project staff carried out numerous activities.

- *Initial Planning Meeting*: The initial project planning meeting was held in Albuquerque, New Mexico (in conjunction with NCAI's Annual meeting) on November 16, 2003. Over 40 federal, state, and tribal representatives from more than 15 states participated in the meeting. Lively discussion resulted in the identification of numerous human service issue areas (both policy and practice related) in which intergovernmental coordination was warranted. Participants also concurred that, rather than prioritizing particular issue areas for project focus, that staff of the joint initiative should look for windows of opportunity to address the varied issues and marshal project support and resources as the identified issues arose. (See Appendix A for a table of issues identified for intergovernmental coordination at the initial project planning meeting.)

- *Federal/State/Tribal Human Service Workgroup*: The Workgroup was established in January 2004 and convened four times in 2004 and three times in 2005 via conference call to continue discussion of areas for intergovernmental coordination, highlight opportunities for forums and human service academies, and give feedback on draft project products. Over the course of the calls, participants discussed child welfare, child support enforcement, TANF, Medicaid, child care, and epidemiological issues. Participants also gave feedback on how best to collect and share best practices in intergovernmental coordination/collaboration. (See Appendix B for a matrix of Workgroup members.)

- *Human Service Policy Academies*: While there was a great deal of interest in the human service policy academy model, it was difficult to find mutually agreeable scheduling options for a critical mass of Workgroup members to participate in policy meetings.

  Notwithstanding such circumstances beyond the Workgroup's control, the Workgroup was successful in supporting two human service academies: one on child welfare and the second on the intersection of TANF and child support enforcement. The child welfare policy academy was held in Seattle, Washington on August 19-20, 2004 in conjunction with another APHSA-sponsored meeting. At this session, over 40 federal, state, and tribal representatives met to identify the key areas for intergovernmental collaboration and to assess child welfare reform policy proposals for their potential impact on Native children and families as well as on state/tribal relationships. HHS Region X had two representatives in attendance (including one representative who was representing Administration for Children, Youth and Families Commissioner Joan Ohl), and the Bureau of Indian Affairs (Central Office) also participated. This is particularly noteworthy because the project went beyond its scope and fostered dialogue between federal agencies. State and tribal representatives from 11 states each made brief presentations about the intergovernmental activities/accomplishments that they were most proud of in their respective states. (Some of the states and the tribes within their boundaries communicated in advance of the meeting in order to coordinate joint presentations.) Evaluations of the meeting indicated that participants were very excited about the information that came out of the meeting and were eager for further opportunities to discuss and coordinate on child welfare issues. A lengthy list of follow-up activities was included in the meeting summary.

  The second policy academy, addressing the intersection of TANF and child support enforcement programs, was convened in Denver, Colorado on December 1, 2005 in conjunction with an HHS Office of Child Support Enforcement meeting of current tribal CSE grantees and the parallel state CSE program staff. Over 50 federal, state, and tribal representatives from 9 states participated in the session. Multiple HHS Regions and Central Office Program Offices, as well as the HHS Office of Intergovernmental Affairs, participated in the session. Regional Director Joe Nunez welcomed everyone to the session, and OCSE Commissioner Margot Bean stayed for the entire meeting, listening to the coordination issues brought forward by tribes and states. The HHS funding for the Initiative allowed the project to reimburse the cost of travel for "start up" tribal CSE staff (that is, tribal grantees with start up grants who are not yet administering the program) and their state counterparts. Bringing this group of program staff and their parallel states to the conversation was a much-heralded accomplishment, as participants noted the lack of opportunity for start up grantees to join existing CSE discussion forums and learn from the experience of tribes and states who are already administering CSE programs.

After a group conversation identifying many issues involving intergovernmental and cross-program coordination (including eligibility determination, enforcement actions, transferring cases, referrals for appropriate services, distribution issues, etc.), participants selected three issues for more focused discussion: cross-training, referrals, and distribution. A meeting summary capturing all of the discussion and highlighting areas for follow-up was produced and shared broadly with all of the meeting participants.

Notably, at the conclusion of the academy, the Federal/State/Tribal Human Service Workgroup met to review and provide feedback on the products of the initiative. While some members of the workgroup were present at the session, others joined the conversation by conference call. Overall, workgroup members expressed enthusiasm about the on-line model practices database and resource guide that will be available by Spring 2006. They also stressed the need to continue to bring forward and address issues of intergovernmental and cross-program coordination beyond the life of the project.

The project was successful in bringing information about this unique three-way intergovernmental partnership into numerous related forums. For example, in a two-year span, the partnership was discussed at 20 HHS national consultation sessions, 3 ACF consultation sessions, 4 national budget sessions, and 16 regional sessions. The partnership was also formally introduced at two national NCAI meetings and a national APHSA meeting. Moreover, all three organizations sent out notices about the project, shared the project overview with constituents, and had numerous conversations with related stakeholders and constituents about the goals of the project.

The project was also successful in sponsoring some federal/state/tribal dialogue opportunities outside of the policy academy model. For example, on May 3, 2004, after the publication of the final Tribal Child Support Enforcement regulation, HHS Office of Child Support Enforcement Commissioner and numerous staff representatives held a 90-minute conference call with tribes and states to review the regulation and take questions about it. In another case, states were invited in to the HHS IGA Regional Tribal Consultation Sessions. In some regions, states were invited to listen to tribal testimony to federal representatives, in other regions, states responded to some of the tribal testimony; and in one region, region IX, the states joined tribal panels in providing testimony to federal officials.

During the Fall 2005 meeting of the National Association of State Medicaid Directors (NASMD), APHSA staff facilitated an opportunity for initial discussion between an informal workgroup of state Medicaid directors and representatives of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG). The group identified several issues of joint concern and discussed avenues for collaborating in the future, including a joint meeting in 2006 of the NASMD Tribal Workgroup and the CMS TTAG. NASMD also held a conference session on tribal health issues that focused on the implementation of Medicare Part D in Indian Country as well as the ability for tribes to determine Medicaid Eligibility.

- *Model Practices Survey and Website*: In August 2005, a brief survey was sent out to states, tribes, and HHS agencies requesting information on any human service projects, initiatives, policies, programs, etc. between tribes, states, and/or the federal government that would be a resource to share with colleagues. (See Appendix C for a copy of the survey that NCAI sent out to tribal governments.) This information was collected to allow tribes, states, and HHS agencies to benefit from the positive experiences, protocols, and processes created by others in such human service areas as TANF and Workforce Development, health, child welfare, child care, child support and food stamps.

The information was obtained with the understanding that it will be compiled and posted on the APHSA website with links from the NCAI and HHS IGA web pages in order for it to be utilized by states, tribes, and the federal government. The survey asked for the specific governments involved in the document or activity, contact information for the state and tribe, as well as the goal or purpose of the document; a description of the main parts or requirements; the funding source used; and an assessment of what has worked as well as suggestions for improvement. When applicable, a link or electronic copy of the supporting documentation was requested. The overall goal however was to collect documents or materials (such as memorandums of agreements, legislation, contracts, pamphlets, training documents, protocols or guidelines) and activities (such as meetings, conferences, consultations practices, data sharing, or workgroups) used to organize or enhance government-to-government (tribal, state, or federal) collaboration and/or coordination. During the course of information gathering, several additional categories emerged: funding/grants; waivers; and staff positions. Following the submissions, the importance of capturing federal grants and funds that states have passed through to tribes or where the state has a federal waiver that includes the delivery of services by tribes was recognized. In addition, as new tribal liaison positions are created in state legislatures, it is worthwhile to capture the roles and responsibilities of these positions.

In all, APHSA and NCAI received over 100 completed surveys, capturing coordination efforts in twenty-four states with over 50 tribes, tribal boards, statewide tribal consortiums, and intertribal councils. The submissions were broken into the categories of: Agreements, Brochures, Consultations/Meetings, Initiatives, Regulations and Waivers, Protocols/Guidelines, Staff Liaison Positions/Staff Assignments, Legislation and Policies, Training Materials, and Work Group/Task Forces. The specific program areas that are covered include: Aging, Health, Child Care, Child Support, Child Welfare, Juvenile Services, Substance Abuse, TANF and Workforce Development, and Vocational Rehabilitation. Some of the documentation that was submitted along with the surveys include a power point presentation on the implementation of the Indian Child Welfare Act, legislation passed in a state that sets out parameters for state staff to consult with tribal governments on specific human service areas, several tribal TANF plans, a brochure on a tribal child support program, contract consolidation guidelines being used in one state to cut down on the paperwork required by tribes, as well as a number of inter-governmental agreements. Surveys are presently being formatted for the web with an expected release in Spring 2006. They will be posted on APHSA's website at www.aphsa.org.

- *Resource Guide*: A comprehensive resource guide that identifies federal, state, and tribal contacts for various human service programs is currently being finalized. This matrix, organized by federal region and by state, will be posted on the Internet to facilitate ongoing updating of information in attempt to keep the guide current. The resource guide includes contact information for federal, state, and tribal staff from TANF, child support, and child welfare programs. Federal CMS contacts are also listed. The guide also notes which tribes administer Low Income Home Energy Assistance Program (LIHEAP), child care, Native Employment Works, and Vocational Rehabilitation programs. From the perspective of Workgroup members, this guide will be invaluable in identifying opportunities for intergovernmental and cross-program coordination. By Spring 2006 it will be posted on APHSA's website (www.aphsa.org) with links from both NCAI's and HHS IGA's websites.

- *Reports/Summaries*: Numerous reports and meeting summaries were produced in conjunction with the project. A meeting summary from the initial planning meeting was compiled and shared with all participants. Best practices and best practice resources identified through the planning meeting were also compiled. Conference call summaries from all of the Federal/State/Tribal Human Service Workgroup calls were compiled and disseminated to the group for review. Documents about the final Tribal Child Support Enforcement regulations and their implications for state/tribal coordination were developed and shared. Numerous previously-written articles and analyses about state/tribal coordination on TANF were shared with interested parties. The summary of the federal/state/tribal Child Welfare meeting and the associated best practices resources were compiled and broadly shared. The summary of the TANF/Child Support Enforcement meeting was shared with all participants. An article co-authored by APHSA and NCAI staff, entitled "Tribal/State Relationships: Increasing Opportunities, Positive Examples and Serious Benefits," was broadly made available. The model practices survey database and the resource guide will both be available on APHSA's website. An Initiative progress report was submitted to the U.S. Department of Health and Human Services and the Workgroup in October 2004 and distributed at Regional Tribal Consultation Sessions sponsored by the Office of Intergovernmental Affairs. Finally, this report constitutes the final project report.

Above and beyond the initiative-specific work, HHS accomplished a number of projects and products that directly contributed to and supported this work. Among them, four are worth special mention: (a) Administration for Children and Families (ACF) Consultations Sessions, (b) Intradepartmental Council on Native American Affairs (ICNAA) Initiative, (c) IGA Tribal Matrix for Regional Consultation and Collaboration, and (d) revision of the HHS Consultation Policy.

- *Administration for Children and Families (ACF) Consultations Sessions:* As a result of the collaborative work with this project, the Commissioner of the Administration for Native Americans implemented ACF-wide Tribal Consultations. The first, co-sponsored by the National Congress of American Indians, was held in Phoenix, AZ in 2003; the second session was held in Washington, DC in 2004, and the most recent session was held in Palm Springs, CA in 2005.

- *ICNAA Departmental Council:* The Secretary's Intradepartmental Council on Native American Affairs also focuses on human services as well as health services. The Council strives to increase awareness and the effectiveness of HHS human services with Native American populations was launched. With the goal of using existing Departmental resources to more effectively inform and efficiently deliver HHS human services to Native American communities, HHS aims to improve access, implementation and administration of human service programs. During national and regional consultation sessions, Tribal and community leaders expressed an interest in learning more about how to access, implement, and receive training and technical assistance in numerous HHS Human Service programs. It is the goal of the HHS to increase access to services to operate programs, and that HHS program offices take the initiative to effectively operate and deliver programs in Native American communities that meet the need of this population.

- *IGA Tribal Matrix for Regional Consultation and Collaboration:* The Office of Intergovernmental Affairs has developed a comprehensive list of Tribal Health and Human Service Organizations that have representatives throughout the country. This matrix is an important resource that HHS Regional Directors and field staff can reach to when conducting consultation with Tribes and States on issues that affect both parties.

- *Revision of the HHS Tribal Consultation Policy*: In 2004, HHS underwent a revision of their Tribal Consultation policy. On January 14, 2005, the revised HHS policy was signed by the

Secretary of Health and Human Services. The revision of this policy included a section devoted to the relationship between HHS, Tribes, and States. In recognition of the fact that, based on statute, regulation, or HHS policy, the authority and appropriations for HHS programs and services to Indian Tribes sometimes flow through the States for the benefit of Indian Tribes, this section of the consultation policy sets an important precedent. It clearly articulates HHS' role in facilitating collaboration between States and Indian Tribes in the same manner that consultation should occur when HHS programs and services are provided directly to an Indian Tribe.

Conclusion

The "Federal-State-Tribal Human Services Partnership" initiative was an ambitious undertaking from the beginning. However, with the support of the leadership from each participating organization, and the work of the core team, much progress was made. Indeed, all three organizations acknowledged a greater acceptance of including tribes and tribal leaders in policy discussions at the state and federal levels.

Throughout the project, however, a number of opportunities for improving the project's effectiveness and overall impact were identified. For example, in order to get around scheduling conflicts that preclude participation in free-standing policy academies, these convenings were piggy-backed onto other meetings that state and tribal human services staff were likely to attend. This preserved scarce travel resources as well as took advantage of existing forums. The project also looked for opportunities to convene interested parties to address common issues by conference call wherever possible.

Resources made available through the Initiative to support/reimburse travel expenses proved critical in allowing participants to be involved in face-to-face meetings. Although participants acknowledged the need for such forums, at both the local/state level and at the national level, travel funds for states and tribes are often limited. Particularly at the national level, where the broadest opportunities for sharing experiences with cross-program and cross-jurisdiction coordination occur, resources are often not available to cover such expenses.

On-going work in the area of intergovernmental collaboration in human services is very much needed and desired by all three parties and our constituents. Although this Initiative has come to a close, all three partnering organizations are committed to highlighting opportunities for continued discussion, finding new ways to share the information collected by the project more broadly, and to institutionalizing the partnership between the organizations.

Appendices

Appendix A……………………………….HHS Federal/State/Tribal Human Services Workgroup
Appendix B……………………………….Table of Issues Identified at Initial Planning Meeting
Appendix C……………………………….Model Practices Survey

Appendix A: HHS Federal/State/Tribal Human Services Workgroup

List of Tribal Delegates and Alternates

Revised June 9, 2004

IHS Area/HHS Region	**DELEGATE** Tribe or Organization	**ALTERNATE** Tribe or Organization
Aberdeen Area (Region 7: Kansas City Region 8: Denver)	Carole Anne Heart Aberdeen Area Tribal Chairman's Health 1770 Rand Road Rapid City, SD 57702 PHONE: 605.721.1922 Fax: 605.721.1932 Email: execdir@norcom-at.com	**Awaiting Tribal Confirmation**
Alaska Area (Region 10: Seattle)	Jana Turvey Kodiak Area Native Assoc. 3449 E. Rezanof Dr. Kodiak, AK 99615 PHONE: 907.486.9802 Fax: 907.486.9889 Email: jana.turvey@kanaweb.org	Mark Andrews Tanana Chiefs Conference 122 1st Ave., Ste. 600 Fairbanks, AK 99701 PHONE: 907.452.8251 ext. 3235 Fax: 907.459.3953 Email: mark.andrews@tananachiefs.org
Albuquerque Area (Regions 6, 8, 9)	No Nomination Submitted	No Nomination Submitted
Bemidji Area (Region 5: Chicago)	Christine McPherson Sault Ste. Marie Tribe of Chippewa 2864 Ashmun St, 3rd floor Sault Ste. Marie, MI 49783 PHONE: 906.632.5273 Fax: 906.632.5266 Email: cmcpherson@saulttribe.net	Hattie Walker Ho-Chunk Nation PO Box 636 Black River Falls, WI 54615 PHONE: 715.284.9343 ext. 5051 Fax: 715.284.9592 Email: hwalker@ho-chunk.com
Billings Area (Region 8: Denver)	Gary James Melbourne Fort Peck Tribe PO Box 1027 Poplar, MT 59255 PHONE: 406.768.3491 Fax: 406.768.5780 Email: hlthdir@nemontel.net	Helen Caplett Crow Tribe PO Box 159 Crow Agency, MT 59022 PHONE: 406.638.3930 Fax: 406.638.4042 Email: helenc@crownations.net
California Area (Region 9: San Francisco)	John P. Carney Riverside-San Bernardino County Indian Health, Inc. 11555 ½ Potrero Rd. Banning, CA 92220 PHONE: 909.849.4761 Fax: 909.849.5881 Email: jcarney123@aol.com	Virginia Hill Coyote Valley Band of Pomo Indians PO Box 1323 Pauma Valley, CA 92061 PHONE: 760.742.0030 Fax: 760.742.0037 Email: seneca7@aol.com
Nashville Area (Region 1: Boston Region 2: New York Region 3: Philadelphia Region 4: Atlanta)	James T. Martin United South & Eastern Tribes, Inc. 711 Stewarts Ferry Pike, Ste. 100 Nashville, TN 37214 PHONE: 615.872.7900 Fax: 615.872.7417 Email: jtmartin@usetinc.org	Brenda Shore Fuller United South & Eastern Tribes, Inc. 711 Stewarts Ferry Pike, Ste. 100 Nashville, TN 37214 PHONE: 615.872.7900 Fax: 615.872.7417 Email: beshore@usetinc.org

IHS Area/HHS Region	**DELEGATE** Tribe or Organization	**ALTERNATE** Tribe or Organization
Navajo Area (Region 6: Dallas Region 8: Denver Region 9: San Francisco)	**Awaiting Tribal Confirmation** Iris Peterson Navajo Division of Social Srv PO Box 4590 Window Rock, AZ 86515 PHONE: 928.871.6837 Fax: 928.871.6278 Email: unknown	**Awaiting Tribal Confirmation** Virgil Pablo Navajo Division of Social Srvs PO Box 4590 Window Rock, AZ 86515 PHONE: 928.871.6837 Fax: 928.871.6278 Email: unknown
Oklahoma Area (Region 6: Dallas Region 7: Kansas City)	Lisa John Chickasaw Nation PO Box 1548 Ada, OK 74821 PHONE: 580.436.7214 Fax: 580.310.6461 Email: lisa.john@chickasaw.net	Norma Merriman Cherokee Nation PO Box 948 Tahlequah, OK 74465 PHONE: 918.456.0671 ext. 2787 Fax: 918.458.7666 Email: nmerriman@cherokee.org
Phoenix Area (Region 8: Denver Region 9: San Francisco)	Warren Kontz Intertribal Council of Arizona 2214 N. Central Ave., Ste. 100 Phoenix, AZ 85004 PHONE: 602.307.1508 Fax: 602.258.4825 Email: warren.kontz@itcaonline.com	Mark Lewis Hopi Tribe PO Box 68 Second Mesa, AZ 86043 PHONE: 928.737.2685 Fax: 928.737.2667 Email: lewism@hopi.wf
Portland Area (Region 10: Seattle)	Robert “Bob” Brisbois Spokane Tribe of Indians P.O. Box 100 Wellpinit, WA 99040 PHONE: 509-258-4581 ext.15 Fax: 509-258-9243 Email: bobbert@spokanetribe.com	Julie Johnson Northwest Indian College PO Box 827 Neah Bay, WA 98357 PHONE: 360.645.2548 Fax: 360.645.2500 Email: juliej@olypen.com
Tucson Area (Region 9: San Francisco)	Reuben Howard Pascua Yaqui Tribe 7490 South Camino de Oeste Tucson, AZ 85743 PHONE: 520.879.6019 Fax: 520.883.1057 Email: reuben.howard@mail.ihs.gov	Rosemary Lopez Tohono O’odham Nation PO Box 815 Sells, AZ 85634 PHONE: 520.383.6000 Fax: 520.383.3930 Email: lopezr@todhs.com

National Organization	DELEGATE	ALTERNATE
American Indian Higher Education Consortium	Dr. Jim Shanley Ft. Peck Community College PO Box 398 Poplar, MT 59255 PHONE: 406.768.6300 Fax: 406.768.6301 Email: jshanley@fpcc.edu	Dr. Dave Gipp United Tribes Technical College 3315 University Drive Bismarck, ND 58504 PHONE: 701.255.3285 ext. 8 Fax: 701.530.0605 Email: dmgipp@aol.com
Association of American Indian Physicians	No Nomination Submitted	No Nomination Submitted
National Council of Urban Indian Health	Donna Keeler South Dakota Urban Indian Health 122 E. Dakota Ave. Pierre, SD 57501 PHONE: 605.224.8841 Fax: 605.224.6852 Email: donnak@sduih.org	Georgiana Ignace 15825 Pomona Rd. Brookfield, WI 53005 PHONE: 262.782.0811 Fax: 414.256.1902 Email: none
National Indian Child Care Association	Dee Killion Eastern Shawnee Tribe PO Box 350 Seneca, MO 64865 PHONE: 918 666.2435 ext. 305 Fax: 918.666.2065 Email: deekill@hotmail.com	Laurie Hand Cherokee Nation PO Box 948 Tahlequah, OK 74465 PHONE: 918.458.7613 ext.223 Fax: 918.458.7616 Email: lhand@cherokee.org
National Indian Child Welfare Association	No Nomination Submitted	No Nomination Submitted
National Indian Council on Aging	Frank Chee Willeto 10501 Montgomery Blvd. NE, Ste. 210 Albuquerque, NM 87111 PHONE: 505.292.2001 Fax: 505.292.1922 Email: none	Harriet Rhoades PO Box 91 Fort Bragg, CA 95437 PHONE: 707.964.2647 Fax: 707.964.4371 Email: noyojetty1@earthlink.net
National Indian Head Start Directors	Mavany Verdugo Rincon Head Start PO Box 946 Pauma Valley, CA 92061 PHONE: 760.751.9821 ext. 333 Fax: 760.751.0572 Email: mavany1@aol.com	Lee Turney Leech Lake Head Start 6530 Highway 2 NW Cass Lake, MN 56633 PHONE: 218.335.8256 Fax: 218.335.8255 Email: llhdstrt@paulbunnan.net
National Indian Health Board	Jerry Freddie HCR 63, Box 6070 Winslow, AZ 86047 PHONE: 928.657.3233 Fax: 928.657.2433 Email: jerry.freddie@navajo.org	Francilla Whiteskunk 101 Constitution Ave. NW Ste. 8-B02 Washington, DC 20001 PHONE: 202.742.4344 Fax: 202.742.4285 Email: fwhiteskunk@nihb.org
Papa Ola Lökahi (Native Hawaiian Health)	Hardy Spoehr 894 Queen St. Honolulu, HI 96822 PHONE: 808.597.6550 ext. 213 Fax: 808.597.6551 Email: hspoehr@papaolalolaki.org	Na’unanikina’u Kamili’i 894 Queen St. Honolulu, HI 96822 PHONE: 808.597.6550 ext. 303 Fax: 808.597.6551 Email: nkamalii@papaolalokahi.org

National Organization	**DELEGATE**	**ALTERNATE**
Tribal Self-Governance Advisory Committee	Melanie A. Benjamin Mille Lacs Band Assembly 43408 Oodena Drive Onamia, MN 56359 PHONE: 800.709.6445 ext. 7479 Fax: 320.532.7505 Email: jmojica@millelacsojibwe.nsn.us	Nomination Withdrawn
Key Point of Contact	**PRIMARY**	**SECONDARY**
HHS Intergovernmental Affairs	Gena Tyner-Dawson 200 Independence Ave. SW, Rm. 630F Washington, DC 20201 PHONE: 202.690.6060 Fax: 202.690.5672 Email: eugenia.tyner-dawson@hhs.gov	James Ivery 200 Independence Ave. SW, Rm. 600E Washington, DC 20201 PHONE: 202.690.6060 Fax: 202.690.5672 Email: james.ivery@hhs.gov
National Congress of American Indians	Jacqueline Johnson 1301 Connecticut Ave. NW, Ste. 200 Washington D.C. 20036 PHONE: 202.466.7767 Fax: 202.466.7797 Email: jjohnson@ncai.org	Sarah Hicks 6221 Rosebury Ave., Apt. #3N Clayton, MO 63105 PHONE: 314.935.5896 Fax: 314.935.8464 Email: shicks@wustl.edu
American Public Health Services Association	Kathryn Dyjak 810 First Street NE, Suite 500 Washington, DC 20002 PHONE: 202.682.0100 ext. 237 Fax: 202.289.6555 Email: kdyjak@aphsa.org	

Appendix B: Table of Issues Identified at Initial Planning Meeting
Joint HHS/APHSA/NCAI Meeting

Broader Issues	Description
Transitioning human service program administration to tribal governments	• Need contact and resource lists • Consultation process between states and tribes • Protocol and sensitivity to issues of sovereignty and culture • Federal barriers to administration by tribes • Capacity building issues and the lack of resources necessary to get a program up and running • Supporting tribal administrators to be able to provide the most integrated services as possible • Need better understanding of state human service budgets, their impact on tribes and Native populations, and how tribes can better support state human service budgets (at the federal and state level)
Coordination when tribal programs are located across federal, state, and county boarders.	• How to support the integration of services while recognizing and dealing with different governments • Definition of "near reservation" and its application to new programs such as TANF
Research, Best Practices, and Training	• Nowhere to gather information on best practices between states and tribes on human service delivery • Little research • Inadequate and/or limited training being provided to tribal programs • Limited state training on working with Native populations
Data Reporting and Information Systems	• Providing tribes with accurate numbers for planning purposes • Limitation of AFCARS data reporting in capturing data for some tribes • Cost prohibitive nature of information systems for many tribal programs • Shared data reporting and issues of confidentiality • Increasing inability of states to deal with manually collected/reported data • Feasibility of EBT systems that include state and tribally provided benefits
Specific Issue Areas	**Description**
Child Care	• Issues around data reporting and accountability • Training of kin providers in respect to new administration initiative towards early learning • Licensing of providers • Dual eligibility of Native families (referrals between state and tribal programs)
Child Support	• Coordination between tribes and states (different program regulations) • Need for technical assistance and the issuance of final tribal regulations • Coordination between child support and child welfare when children are involved in both systems and in state and tribal programs.

Specific Issue Areas	Description
Child Welfare	• The Indian Child Welfare Act and intersection with the Adoption and Safe Families Act (ASFA) • Title IV-E child welfare system and intersections with the child support system • Ability for tribes to receive direct reimbursement for IV-E foster care and adoption; tribes have fewer overall child welfare funding resources • Cultural issues that arise (such as the definition of "guardian" and "family") during the termination of parental rights (TPR) process and the placement of children outside the home • Over-representation of Indian youth in the juvenile justice system • Many state juvenile justice systems do not allow for alternative approaches (that emphasize cultural, religious and tribal practices) to working with youth to allow for alternative, treatment-oriented approaches
Food Stamps	• Ability for tribes to administer program • Overcoming issue of expensive vendors in order to operate Electronic Benefit Transfers (EBT) • Quality Control (QC) error rates and accountability • Intersection between commodity program and food stamps if tribes take on administration of food stamp program
Public Health and Medicaid	• Opportunity for tribes to determine Medicaid eligibility and receiving waiver approvals • Interpretation of the Indian Health Care Improvement Act and 100% federal medical assistance percentage • Opportunities for state and tribal Medicaid directors to have joint meeting or discussions • Availability of federal services to states yet not tribes • HIPPA and relationship to Medicaid • Confusion about presumptive eligibility for medical assistance and TANF • Need for better understanding of treaty rights and Medicaid coverage • Lack of reimbursements for tribally provided services to non-Indians who are married to Indians on the reservation • Coordination of substance abuse, mental health, and Medicaid programs
Temporary Assistance for Needy Families (TANF)	• Recognition and role of Tribal TANF in economic development • Identifying State TANF activities that count as work in areas of high unemployment (if Senate language on this provision is maintained) • Clarification of process for determining federal block grant amount when new tribes take on TANF in same service area • Tribal TANF programs that cross state boundaries • Coordination of expanded service areas, especially in urban areas

Appendix C: Model Practices Survey

To: Tribal Social Services Directors

From: The National Congress of American Indians

Date: August 5, 2005

Re: National Tribal Survey on Mechanisms to Facilitate Better Intergovernmental Relationships in Human Services Delivery

As part of a joint initiative between the National Congress of American Indians (NCAI), the American Public Human Services Association (APHSA), and the Department of Health and Human Services, Office of Inter-governmental Affairs (HHS), we are requesting information on any human service projects, initiatives, policies, programs, etc. between tribes, states, and/or the federal government that would be a resource to your colleagues. We are collecting this information so that tribes, states, and HHS agencies are able to benefit from the positive experiences, protocols, and processes created by others in such human service areas as TANF, health, child welfare, child care, and food stamps. **In particular, we are soliciting the following information with the understanding that it will be compiled and posted on our website in order for it to be shared and utilized by other states and tribes:**

- Documents or materials (such as memorandums of agreement, legislation, contracts, pamphlets, training documents, protocols, or guidelines) you use to enhance government to government (tribal, state, or federal) collaboration and/or coordination.

- Activities (such as meetings, conferences, consultation practices, data sharing, or workgroups) you organize or take part in to enhance government to government (tribal, state, or federal) collaboration and/or coordination.

We ask your help by completing the following survey by August 29, 2005. I have enclosed a draft one-page summary of how we hope to present the information. We have received some materials from previous meetings and will post materials as submitted. An electronic copy of the survey is available for your convenience. If you would like to fill out the survey electronically, please e-mail me. If you have any questions, please feel free to contact me at (202) 466-7767 or jrackliff@ncai.org.

Thanks for your help!

Jennifer Rackliff
The National Congress of American Indians
1301 Connecticut Avenue, NW
Suite 200
Washington, DC 20036

Government to Government Collaborations in Human Services
Useful Documents Survey
Response Deadline: COB *MONDAY, AUGUST 29, 2005*

Please use a separate form for each document or activity submitted.

Tribe/State/HHS Agency or Department:
Contact Person: ____
Title: ____
Mailing address: ____
City / State: __________________________ Zip: _____________________
Phone: _________________________ Fax: _________________________
E mail: ____

1) Name/unique identifier of document or activity: ______________________
If a document, what type?

☐ Agreement ☐ Guidelines ☐ Legislation ☐ Regulation

☐ Pamphlet ☐ Protocol ☐ Training materials

If an activity, what type?

☐ Conference/Meeting ☐ Consultation ☐ Data Sharing

☐ Training ☐ Workgroup ☐ Other specify:______________

2) Please identify what governments are involved:
Tribes: ____

☐ State-Recognized ☐ Federally-Recognized

States: ____

Counties: ____

HHS Agencies: ____

Date of implementation: ____

Present Status: ☐ on-going ☐ completed ☐ not yet implemented

List what programs this applies to or if it is statewide (e.g. applying to all human service programs):

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3) Brief description:

- ❖ What was/is the goal and purpose of the document/activity?

- ❖ Please identify the main parts or requirements of the document or the activity.

- ❖ What was the source of funding used to develop or implement the document/event?

❖ What has worked and what could be changed to improve it?

❖ *If there is information about the document/activity on the web, please enclose the weblink:*

Mail or email completed survey to the name below. Please enclose a copy of any document or activity description you are describing, as well as any type of additional materials you would like to share.

Jennifer Rackliff
The National Congress of American Indians
1301 Connecticut Avenue, NW
Suite 200
Washington, DC 20036
E-mail completed forms to: jrackliff@ncai.org
Fax: (202) 466-7797

F: TRIBAL CONSULTATION POLICY (2005)

DEPARTMENT TRIBAL CONSULTATION POLICY
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. INTRODUCTION

The Department of Health and Human Services (HHS) and Indian Tribes share the goal of eliminating health and human service disparities of American Indians and Alaska Natives (AI/AN) and ensuring that access to critical health and human services is maximized. To achieve this goal, and to the extent practicable and permitted by law, it is essential that federally-recognized Indian Tribes and the HHS engage in open, continuous, and meaningful consultation. True consultation leads to information exchange, mutual understanding, and informed decision-making. The importance of consultation with Indian Tribes was affirmed through Presidential Memoranda in 1994 and 2004, and an Executive Order in 2000.

2. BACKGROUND

Since the formation of the Union, the United States (U.S.) has recognized Indian Tribes as sovereign nations. A unique government-to-government relationship exists between AI/AN Indian Tribes and the Federal Government. This relationship is grounded in numerous treaties, statutes, and executive orders as well as political, legal, moral, and ethical principles. This relationship is not based upon race, but rather, is derived from the government-to-government relationship. The Federal Government has enacted numerous regulations that establish and define a trust relationship with Indian Tribes.

An integral element of this government-to-government relationship is that consultation occurs with Indian Tribes. This policy applies to all Divisions of the Department. Divisions shall provide an opportunity for Tribes to participate in policy development to the greatest extent practicable and permitted by law. Executive Memorandum entitled "Government-to-Government Relationship with Tribal Governments" reaffirmed this government-to-government relationship with Indian Tribes on September 23, 2004. The implementation of this policy is in recognition of this special relationship.

This special relationship is affirmed in statutes and various Presidential Executive Orders including, but not limited to:

- Older Americans Act, P.L. 89-73, as amended;
- Indian Self-Determination and Education Assistance Act, P.L. 93-638, as amended;
- Native Americans Programs Act, P.L. 93-644, as amended;
- Indian Health Care Improvement Act, P.L. 94-437, as amended;
- Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L.104-193;
- Presidential Executive Memorandum to the Heads of Executive Departments dated April 29, 1994;
- Presidential Executive Order 13175, Consultation and Coordination with Indian Tribal Governments, November 6, 2000; and
- Presidential Memorandum, Government-to-Government Relationship with Tribal Governments, September 23, 2004

3. TRIBAL SOVEREIGNTY

This policy does not waive any Tribal Governmental rights, including treaty rights, sovereign immunities or jurisdiction. Additionally, this policy does not diminish any rights or protections afforded other AI/AN persons or entities under Federal law.

Our Nation, under the law of the U.S. and in accordance with treaties, statutes, Executive Orders (EO), and judicial decisions, has recognized the right of Indian Tribes to self-government and self-determination. Indian Tribes exercise inherent sovereign powers over their members and territory. The U.S. continues to work with Indian Tribes on a government-to-government basis to address issues concerning Tribal self-government, Tribal trust resources, Tribal treaties and other rights.

The constitutional relationship among sovereign governments is inherent in the very structure of the Constitution, and is formalized in and protected by Article I, Section 8. Increasingly, this special relationship has emphasized self-determination and meaningful involvement for Indian Tribes in Federal decision-making (consultation) where such decisions affect Indian Tribes. The involvement of Indian Tribes in the development of public health and human services policy allows for locally relevant and culturally appropriate approaches to public issues.

Tribal self-government has been demonstrated to improve and perpetuate the government-to-government relationship and strengthen Tribal control over federal funding that it receives, and its internal program management.

4. POLICY

It is the HHS policy that consultation with Indian Tribes will occur to the extent practicable and permitted by law before any action is taken that will significantly affect Indian Tribes. Such actions refer to policies that have Tribal implications and that have substantial direct effects on one or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes.

Nothing in this policy waives the Government's deliberative process privilege. For example, in instances where the Department is specifically requested by Members of Congress to respond to or report on proposed legislation, the development of such responses and of related policy is a part of the Executive Branch's deliberative process privilege and should remain confidential. In addition, in specified instances where Congress requires the Department to work with Tribes on the development of recommendations that may require legislation, such reports, recommendations or other products are developed independent of a Department position, the development of which is governed by Office of Management and Budget (OMB)-Circular A-19.

A. Each HHS Operating and Staff Division (Division) shall have an accountable process to ensure meaningful and timely input by Tribal officials in the development of policies that have Tribal implications.

B. To the extent practicable and permitted by law, no Division shall promulgate any regulation that has Tribal implications, that imposes substantial direct compliance costs on Indian Tribes, or that is not required by statute, unless:

1. Funds necessary to pay the direct costs incurred by the Indian Tribe in complying with the regulation are provided by the Federal Government; or

2. The Division, prior to the formal promulgation of the regulation,
    a) Consulted with Tribal officials early and throughout the process of developing the proposed regulation;

    b) Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the *Federal Register* (FR), which consists of a description of the extent of the Division's prior consultation with Tribal officials, a summary of the nature of their concerns and the Division's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of Tribal officials have been met; and

c) Made available to the Secretary any written communications submitted to the Division by Tribal officials.

C. To the extent practicable and permitted by law, no Division shall promulgate any regulation that has Tribal implications and that preempts Tribal law unless the Division, prior to the formal promulgation of the regulation,

1. Consulted with Tribal officials early and throughout the process of developing the proposed regulation;

2. Provided a Tribal summary impact statement in a separately identified portion of the preamble to the regulation as it is to be issued in the FR, which consists of a description of the extent of the Division's prior consultation with Tribal officials, a summary of the nature of their concerns and the Division's position supporting the need to issue the regulation, and a statement of the extent to which the concerns of Tribal officials have been met; and

3. Made available to the Secretary any written communications submitted to the Division by Tribal officials.

D. On issues relating to Tribal self-governance, Tribal self-determination, Tribal trust resources, or Tribal treaty and other rights, each Division should explore, and where appropriate, use consensual mechanisms for developing regulations, including negotiated rulemaking.

E. The special "Tribal-Federal" relationship is based on the government-to-government relationship, however, other statutes and policies exist that allow for consultation with urban Indian organizations, non-federally recognized Tribal groups, governing bodies of Indian Tribes on Federal and State Reservations, State Recognized Tribes, other Indian organizations, Native Hawaiians, Native American Pacific Islanders (including American Samoan Natives), and other Native American groups, that, by the sheer nature of their business, serve American Indians, Alaska Natives or Native Americans and might be negatively affected if excluded from the consultation process. Section 9.B. of this policy describes when HHS will consult with other groups.

Even though some of the organizations and groups do not represent federally-recognized Tribal governments, the Department is able to consult with these groups individually. However, if the Department wants to include organizations which do not represent a specific federally-recognized Tribal government on advisory committees or workgroups then Federal Advisory Committee Act (FACA) requirements must be followed.

5. PHILOSOPHY

Indian Tribes have an inalienable and inherent right to self-governance. Self-governance means government in which decisions are made by the people who are most directly affected by the decisions. As sovereign nations, Indian Tribes exercise inherent sovereign powers over their members, territory and lands.

HHS has a long-standing commitment to working on a government-to-government basis with Indian Tribes and to work in partnership with AI/ANs. Also, HHS is committed to enhancing the collaboration among its Divisions to address Tribal issues and promoting the principle that each Division bears responsibility for addressing Tribal issues within the context of their mission.

The Office of Intergovernmental Affairs (IGA) is identified as the responsible organization within HHS for monitoring compliance with EO 13175 and the Department Tribal Consultation Policy. In addition, the Secretary has charged the Intradepartmental Council on Native American Affairs (ICNAA) to meet semi-annually and to provide advice on all HHS policies that relate to American Indians/Alaska Natives/Native Americans (AI/AN/NA). Regional consultation sessions have been developed as a systematic method to regularly consult with Indian Tribes on HHS programs at field locations. The goal of these efforts is to focus HHS on Tribal issues, to continue to enhance the government-to-government relationship between Indian Tribes and the U.S., as well as to make resources of HHS more readily available to Indian Tribes.

6. OBJECTIVES

1. To formalize the requirement of HHS to seek consultation and the participation of Indian Tribes in policy development and program activities to ensure that health and human service priorities and goals are recognized.

2. To establish a minimum set of requirements and expectations with respect to consultation and participation throughout HHS management, the Office of the Secretary (OS), Division, and Regional levels.

3. To identify critical events at which Tribal consultation and participation will be required for all levels of HHS management, the OS, by each Division, and the Regional level.

4. To identify events and partnerships that HHS would participate with Tribal and Native Organizations that will establish and foster partnerships to complement and enhance consultation with Indian Tribes.

5. To promote and develop innovative methods of involving Indian Tribes in HHS policy development and regulatory processes.

6. To uphold the responsibility of HHS to consult with Indian Tribes on new and existing health and human service policies, programs, functions, services and activities that have Tribal implications.

7. To charge and hold accountable each of the Division Heads for the implementation of this policy.

8. To be responsive to an Indian Tribe's request for consultation and technical assistance in obtaining HHS resources.

9. To charge the Divisions with the responsibility for enhancing partnerships with Indian Tribes which will include, technical assistance, access to programs and resources.

10. To provide a single point of contact within HHS for Indian Tribes at a level that has access to the Immediate Office of the Secretary (IOS), the Deputy Secretary, Regions, and Divisions. The Senior Advisor for Tribal Affairs will serve as the Department's point of contact in accessing department-wide information. Each Division will designate a representative through the ICNAA to serve as a Liaison and a Division point of contact for Indian Tribes.

7. ROLES

1. **Indian Tribes**: The government-to-government relationship between the U.S. and Indian Tribes dictates that the principal focus for HHS consultation is with individual Indian Tribes.

2. **Tribal Organizations**: It is frequently necessary that the HHS communicate with Tribal organizations/committees to solicit consensual Tribal advice and recommendations. Although the special "Tribal-Federal" relationship is based on the government-to-government relationship with Indian Tribes, other statutes and policies exist that allow for consultation with other Tribal organizations. These organizations by the sheer nature of their business serve and represent Indian Tribes issues and concerns that might be negatively affected if these organizations were excluded from the consultation process.

3. **Native Organizations**: It is frequently necessary that HHS communicate with Native organizations/committees to solicit consensual advice and recommendations. Although the special "Tribal-Federal" relationship is based on the government-to-government relationship, other statutes and policies exist that allow for consultation with other Native organizations. These organizations, by the sheer nature of their business, serve and represent Native issues and concerns that might be negatively affected if these organizations were excluded from the consultation process. Section 9. B. of this policy describes when HHS will consult with other groups.

   Even though some of the organizations and groups do not represent federally recognized Tribal governments, the Department is able to consult with these groups individually. However, if the Department wants to include organizations which do not represent a specific federally recognized Tribal government on advisory committees or workgroups then FACA requirements must be followed.

4. **Office of Intergovernmental Affairs**: IGA is responsible for Department-wide implementation and monitoring of EO 13175 for HHS Tribal consultation. IGA serves as the Department's point of contact in accessing department-wide information. The single point of contact within the IGA for Indian Tribes and other Native organizations, at a level with access to all Divisions, is the Senior Advisor for Tribal Affairs. As a part of the IOS, the IGA's mission is to facilitate communication regarding HHS initiatives as they relate to Tribal, State, and local governments. IGA is the Departmental liaison to States and Indian Tribes, and serves the dual role of representing the States and Tribal perspective in the federal policymaking process, as well as, clarifying the federal perspective to States and Indian Tribes, including Tribal consultation.

5. **Assistant Secretary for Budget, Technology, and Finance**: The Assistant Secretary for Budget, Technology, and Finance (ASBTF) is the lead office for budget consultation for the overall departmental budget request. The IGA supports the ICNAA and ASBTF as the coordinating office within the IOS for communications among Regional Offices, Divisions and the ICNAA.

6. **Intradepartmental Council on Native American Affairs**: The Secretary's ICNAA plays a critical role in the execution of the HHS consultation policy. The ICNAA is charged to: (1) develop and promote an HHS policy to provide greater access and quality services for AI/AN/NAs throughout the Department, (2) promote implementation of HHS policy and Division plans on consultation with AI/AN/NAs and Indian Tribes in accordance with statutes and EOs, (3) promote an effective, meaningful AI/AN/NA policy to improve health and human services for AI/AN/NAs, (4) develop a comprehensive Departmental strategy that promotes self-sufficiency and self-determination for all AI/AN/NA people, and (5) promote the Tribal/Federal government-to-government relationship on an HHS-wide basis in accordance with EO 13175. The underpinning concept of the Council is the premise within HHS that all Divisions bear responsibility for the government's obligation to Native Americans.

7. **Regional Offices**: The ten (10) HHS Regional Offices share in the Department-wide responsibility to coordinate and communicate with Indian Tribes on issues that affect Indian Tribes and States. The Regional Directors are the Secretary's immediate representatives in the field for the HHS. Each Regional Office is to conduct an annual regional Tribal consultation with Indian Tribes in their respective regions. Further, the Regional Directors will work closely with the respective Indian Tribes and State Governments to assure continuous coordination and communication between Tribes and States.

8. **HHS Divisions**: The Department has numerous Staff Divisions and Operating Divisions under its purview. Each of the these Divisions share in the Department-wide responsibility to coordinate, communicate and consult with Indian Tribes on issues that affect these governments. All Staff Divisions will comply with the Department Tribal Consultation Policy. Additionally, all Operating Divisions will

comply with this policy and revise their own Tribal consultation policy or plan to conform to this Policy. All Divisions are responsible for conducting Tribal consultation to the extent practicable and permitted by law on policies that have Tribal implications.

8. TRIBAL CONSULTATION

A. Consultation occurs:

1. When the HHS Secretary/Deputy Secretary, or their designee, and a Tribal President/Chair/Governor and/or elected/appointed Tribal Leader meet or exchange written correspondence to discuss issues concerning either party.

2. When a Division Head meets or exchanges written correspondence with an elected/appointed Tribal Leader to discuss issues or concerns of either party.

3. When a Regional Director, or their designee, who is the Secretary's representative in the field meets or exchanges written correspondence with an elected/appointed Tribal Leader to discuss issues or concerns of either party.

4. When the Secretary/Deputy Secretary/Division Head, or their designee, meets or exchanges written correspondence with a Tribal representative designated by an elected/appointed Tribal leader to discuss issues or concerns of either party.

B. Consultation Criteria: Trust between HHS and Indian Tribes is an indispensable element in establishing a good consultative relationship. The degree and extent of consultation will depend on the identified critical event. While this policy does not provide specific guidelines, Divisions shall utilize the following criteria to ensure that the requirements of this policy are satisfied.

1. Identify the Critical Event: Complexity, implications, time constraints, issue (funding, policy, programs)

2. Identify affected/potentially affected Indian Tribe(s), etc.

3. Determine level of Consultation – The level of consultation can be determined after considering the critical event and Indian Tribes affected/potentially affected.

    1) **Correspondence**: Written communications should clearly provide affected/potentially affected Indian Tribes of the critical event and the manner in which to provide comment. The HHS frequently uses a "Dear Tribal Leader Letter" (DTLL) format to notify individual Indian Tribes of consultation activities. Divisions should work closely with IGA if technical assistance is required for proper format, current mailing lists, and content.

    2) **Meeting(s)**: The Divisions shall convene a meeting with affected/potentially affected Indian Tribes to discuss all pertinent issues in a national or regional

forum, or as appropriate, to the extent practicable and permitted by law, when the critical event is determined to have substantial direct impact.

Other types of meetings and/or conferences occur which may not be considered consultation sessions, but these meetings may provide an opportunity to share information, conduct workshops, and provide technical assistance to Indian Tribes.

3) **Notice**: Upon the determination of the level of consultation necessary, proper notice of the critical event and the level of consultation utilized shall be communicated to affected/potentially affected Indian Tribes using all appropriate methods including mailing, broadcast e-mail, FR, and other outlets. The FR is the most formal HHS form of notice used for consultation.

4) **Receipt of Comment**: The Division shall develop clear and explicit instructions for the submission of comments.

5) **Reporting of Outcome**: The Division shall report on the outcomes of the consultation.

C. **Tribal Resolution**: Communications from Indian Tribes frequently come in the form of Tribal resolutions. These resolutions may be the most formal declaration of an Indian Tribe's position for the purpose of Tribal consultation. Once the Division receives a Tribal resolution, the Division should respond appropriately. Appropriate response may include Tribal consultation.

D. **Schedule For Consultation**: Divisions must establish and adhere to a formal schedule of meetings to consult with Tribal governments and representatives concerning the planning, conduct, and administration of applicable activities. Divisions must involve Tribal representatives in meetings at every practicable opportunity. Divisions are encouraged to establish additional forums for Tribal consultation and participation, and for information sharing with Tribal leadership. Consultation schedules should be forwarded to IGA to be posted on the IGA website and to check for duplication or conflicts with other national Tribal events and HHS consultation sessions.

E. **Policy Development Through Tribal Consultation Process**: The need to develop a policy may be identified from within the Division or may be identified by Indian Tribes. This need may result from external forces such as Executive, Judicial, or Legislative Branch directives. Once the need to develop a policy is identified the consultation process must begin in accordance with critical events and level of consultation. The Divisions may request technical assistance from IGA for the Tribal consultation process.

9. CONSULTATION PROCESS

A. Tribal

1. Work sessions will be held to solicit official Tribal comments and recommendations on policy and budget matters affecting Indian Tribes. These sessions at roundtables, forums and meetings will provide the opportunity for meaningful dialogue and effective participation by Indian Tribes.

2. Indian Tribes have the ability to meet one-on-one with a Division Head or designated representative to consult on issues specific to that Indian Tribe.

3. The IGA or Division upon completion of a consultation session will document and follow-up on any unresolved issues that would benefit from ongoing involvement of Indian Tribes in implementation and evaluation.

4. IGA will consult with Tribally-elected/appointed Leader on the Tribal consultation policy to ensure effective and meaningful participation.

5. The HHS Tribal consultation policy will be posted on the HHS website homepage and offered to appropriate Tribal and Native organization websites.

6. IGA will continue to inform Indian Tribes on the Tribal Consultation Policy by conducting meetings, roundtables, teleconferences, forums, and placing information on the HHS website homepage and other appropriate websites.

7. Specific mechanisms that will be used to consult with Tribal governments include, but are not limited to: mailings, meetings, teleconferences, and roundtables.

B. **Consultation with Other Groups**: In cases where the government-to-government relationship does not exist, consultation is encouraged to the extent that a conflict of interest does not exist with Federal statutes or the Division authorizing legislation. Some aspects of this consultation are set out in statute and administrative policy.

Even though the organizations and/or groups do not represent federally recognized Tribal governments, the Department is able to consult with these groups individually. However, if the Department wants to include organizations which do not represent specific federally-recognized Tribal governments on advisory committees or workgroups then FACA requirements must be followed. The intergovernmental committee exemption to FACA is found under 2 U.S.C. 1534. As a result, the Department is required to adhere to FACA when such organizations are made a part of an advisory committee or workgroup.

The Secretary's ICNAA is responsible for ensuring inclusion of the organizations and groups in policies affecting Native Americans Department-wide. The ICNAA will work closely with IGA, Regional Directors and the Divisions to identify those instances when other Native American non-governmental organizations and groups may be negatively affected if excluded from the consultation process such as urban Indian organizations, non-federally recognized Tribal groups, governing bodies of Indian Tribes on Federal and State Reservations, State Recognized Tribes, other Indian organizations, Native Hawaiians, Native American Pacific Islanders (including American Samoan Natives), and other Native American groups that, by the sheer nature of their business, serve American Indians, Alaska Natives or Native Americans.

Although consultation may be allowed with these organizations, non-federally recognized Tribes and Tribal organizations listed above do not fall under the intergovernmental committee exemption to FACA found under 2 U.S.C. 1534. As a result, the agency is required to adhere to FACA when such organizations are made a part of an advisory committee or workgroup.

The ICNAA will work with IGA and the Divisions to facilitate any required consultation forums, the level of consultation required, recording of meetings, evaluate the results, determine whether additional consultation on policy items may be needed, and report to the affected Native American groups and non-governmental Indian and Native organizations.

C. States:

1. In some instances, the authority and appropriations for HHS programs and services to Indian Tribes flow through the States for the benefit of Indian Tribes, based on statute, regulation or HHS policy. It is important that HHS facilitate collaboration between States and Indian Tribes to assist with consultation in the same manner should HHS programs and services be provided directly to an Indian Tribe.

2. When States are authorized to administer HHS programs, services, and funding for the benefit of Indian Tribes and AI/ANs, IGA will collaborate with Divisions to assist States in developing mechanisms for consultation with Indian Tribes before taking any actions that have substantial direct effects on Indian Tribes. HHS will recommend the development of State plans for Tribal consultation. States will receive HHS technical assistance in developing these plans.

3. IGA, Regional Directors, and Divisions will assist States to consult with Indian Tribes in a meaningful manner that is consistent with the definition of "consultation" as defined in this policy. Divisions will communicate the input received through Tribal consultation to the States through the appropriate program(s) and work with the Regional Directors to facilitate collaboration between Indian Tribes, States, and HHS.

4. IGA will assist Divisions in helping States develop and implement plans on Tribal consultation to assist States with intergovernmental communications with Indian Tribes. Regional Directors and Regional Office staff will provide technical assistance to States and Indian Tribes for the Tribal consultation process.

5. When a Division foresees the possibility of a conflict between Tribal and State laws and Federally protected interests within its area of regulatory responsibility, the Division shall consult, to the extent practicable and permitted by law, with appropriate Indian Tribes and/or States in an effort to facilitate a dialogue.

6. IGA and Regional Directors are encouraged to invite and include State governmental, health, and human services experts in the Annual Regional Tribal Consultation Sessions whenever Indian Tribes express that State/Tribal dialogue is necessary to enhance and strengthen HHS health and human services and programs.

7. IGA shall provide guidelines that define how the Divisions will monitor and evaluate State plans to meet Tribal consultation meetings, forums, and/or sessions with Indian Tribes for HHS programs and services administered by or through a State for Indian Tribes. HHS will address State plans in situations where the evaluation has identified deficiencies in the consultation process as set forth in this policy, and work closely with States to strengthen consultation necessary for HHS funded programs and services for Indian Tribes and AI/ANs.

8. Regional Directors and HHS Divisions will measure and report on their interaction with States to facilitate and provide Tribal consultation technical assistance to States and Indian Tribes. Divisions will include their efforts in the IGA Annual Tribal Consultation Report.

D. Regional Tribal Consultation:

1. The HHS Regional Tribal Consultation Sessions are designed to solicit Indian Tribe's priorities and needs on health and human services and programs. The Sessions will provide an opportunity for Indian Tribes to articulate their comments and concerns on budgets, regulations, legislation and HHS health and human services policy matters.

2. Regional Offices/Directors and Divisions will work collaboratively with the Indian Tribes in their respective Regions on the development of consultation meetings, roundtables and annual sessions.

3. Regional Offices/Directors and Divisions will work with the Indian Tribes to identify regional Tribal and Native organizations that assist in representing the Indian Tribes in planning Tribal consultation sessions.

4. Regional Offices/Directors and Divisions will work collaboratively with the Indian Health Service (IHS) Area Directors in communicating and coordinating on issues and concerns of Indian Tribes in those respective regions or areas.

5. Regional Offices/Directors and Divisions will work collaboratively to facilitate Tribal-State relations as they affect Indian Tribes and AI/ANs.

10. ESTABLISHMENT OF JOINT TRIBAL/FEDERAL WORKGROUPS AND/OR TASK FORCES

A. Consultation:

1. **New Policy**: When new or revised national policy/policies affect an Indian Tribe/Tribes, HHS may establish a workgroup and/or task force to develop recommendations on various technical, legal, or policy issues. In such cases, the following process is generally followed:

    a) **Joint Tribal/Federal Workgroups and/or Taskforces**: Although the special "Tribal-Federal" relationship is based in part on the government-to-government relationship it is frequently necessary for HHS to establish Joint Tribal/Federal Workgroups and/or Task Forces to complete work needed to develop new policies, practices, issues, and/or concerns and/or modify existing policies, practices, issues, and/or concerns. These Joint Tribal/Federal Workgroups and/or Task Forces do not take the place of Tribal consultation, but offer an enhancement by gathering individuals with extensive knowledge of a particular policy, practice, issue and/or concern to work collaboratively and offer recommendations for consideration by federally recognized Tribal governments and federal agencies. The subsequent work products and/or outcomes developed by the Joint Tribal/Federal Workgroup and/or Task Forces will be handled in accordance with this policy.

    b) **Membership Notices**: The Department is allowed to meet with various representatives of organizations on an individual basis. However, if the Department or Division desires to form an advisory committee or workgroup, which includes representatives from organizations, assurance must be provided to the IGA which demonstrates compliance with FACA. If such organizations are exempt from FACA because of the intergovernmental committee exemption found under U.S.C. 1534, then documentation must be provided to IGA. In order to assure compliance with FACA requirements and exemptions, advice from agency counsel may be sought prior to formation of advisory committees or workgroups.

c) **Meeting Notices**: The purpose, preliminary charge, time frame, and other specific tasks shall be clearly identified in the notice. All meetings should be open and widely publicized ideally through IGA or the Division initiating the policy.

d) **Workgroups**: Tribal membership should be selected based on the responses received from prospective volunteers as a result of the notice, and if possible, should represent a cross-section of affected parties. HHS staff may serve in a technical advisory capacity.

B. Participation:

1. **Attendance at Meetings**: Workgroup members must make a good faith effort to attend all meetings. Other individuals may accompany members, as that member believes is appropriate to represent his/her interest.

2. **Appointment of Alternates**: Each workgroup member may appoint an alternate by written notification. In cases where an elected Tribal leader appoints an alternate who is not an elected official, the alternate shall represent the primary member on a workgroup. The alternate will have the same voting rights as the primary member, as designated in the letter by that Tribal leader.

3. **Workgroup Protocols**: The workgroup may establish protocols to govern the meetings. Such protocols will include, but are not limited to the following:
    a) Selection of workgroup co-chairs, if applicable

    b) Role of workgroup members

    c) Process for decision-making (consensus based or otherwise)

    d) Process for determining drafting and availability of all final workgroup products and documents

4. **Workgroup Charge**: Prior to the workgroup formulation, the HHS may develop an initial workgroup charge in enough detail to define the policy concept. The workgroup will develop recommendations for the final workgroup charge for the approval of the HHS Secretary, the IGA Director or the Division head.

5. **Workgroup Final Products**: Once a final draft of the workgroup has been created by the workgroup the following process will be used to facilitate additional consultation:

a) Upon completion, the draft policy documents will be distributed informally to Indian Tribes, National Tribal and Native Organizations for review and comment and to allow for maximum possible informal review.

b) Comments will be returned to the workgroup, which will meet in a timely manner to discuss the comments and determine the next course of action.

c) If the proposed policy is considered to be substantially complete as written, the workgroup will forward the draft policy to the HHS Secretary as final recommendation for consideration.

d) The workgroup will also recognize any contrary comments in its final report.

e) If it is determined that the policy should be rewritten, the workgroup will rewrite and begin informal consultation again at the initial step above.

f) If the proposed policy is generally acceptable to the HHS Secretary, final processing of the policy by the workgroup will be accomplished.

6. **Recommendations and Policy Implementation**: All final recommendations made by the workgroup should be presented to the Secretary. Before any final policy decisions are adopted within HHS, the proposed policy shall be widely publicized and circulated for review and comment to Indian Tribes, National Tribal Organizations, other Native organizations, and within HHS. Once the consultation process is complete and a proposed policy is approved and issued, the final policy shall be broadly distributed to all Indian Tribes.

11. HEALTH AND HUMAN SERVICES BUDGET FORMULATION

1. **Performance Budget Formulation**: HHS ensures the active participation of Indian Tribes in the formulation of the HHS performance budget request as it pertains to Indian Tribes.

2. **Operating Division Consultation Plan**: Each Division Consultation Plan includes a description of how the Division consults with Indian Tribes regarding the formulation of the annual budget.

3. **National Divisional Tribal Budget Formulation and Consultation Session**: A national budget formulation session that includes each Operating and Staff Division that has involvement in Tribal activities is conducted annually to give Tribes and Tribal Organizations the opportunity to present their health and human services priority recommendations as a comprehensive set of national priorities and a proposed budget request. The intent of these sessions is to permit Divisions to consider Tribal comments as they prepare their budgets for submission to the Office of the Secretary. In order for Divisions to receive and consider Tribal recommendations in the development of the budget request, this session is conducted no later than March 15 of each year.

4. **National HHS Tribal Budget Formulation and Consultation Session**: An annual, Department-wide Tribal budget formulation and consultation session is conducted to give Indian Tribes the opportunity to present their budget priorities/recommendations to the Department with participation of the ICNAA to ensure priorities/recommendations are addressed as HHS prepares to receive the budget requests of its Divisions. The session is convened in May of each year as a means for final input in the development of the Department's budget submission to OMB.

5. **Intradepartmental Council on Native American Affairs**: The ICNAA represents the internal HHS team providing direction across the Divisions for AI/AN/NA issues. The Tribal priorities and budget recommendations presented at the Divisional Meeting and Regional Consultation Sessions are compiled by the IGA and presented to the ICNAA.

   One of the primary responsibilities of IGA/ICNAA is to solicit Tribal input in establishing the health and human service budget priorities and recommendations for their respective Divisions.

   The health and human service priorities established by Indian Tribes are used to inform the development of the Divisions' annual performance measures for improving health and human services, which are linked to their budget requests.

6. **Budget Information Disclosure**: HHS provides Indian Tribes the HHS budget related information on an annual basis: appropriations, allocation, expenditures, and funding levels for programs, services, functions, and activities.

12. MEASURING HHS TRIBAL CONSULTATION PERFORMANCE AND COLLABORATION

As part of the IGA Annual Tribal Consultation Report, Divisions will measure and report results and outcomes of their Tribal consultation performance to fulfill the government-to-government relationship with Indian Tribes.

The Department mission and the Department-wide performance objectives are designed to enhance the health and well-being of Americans by providing for effective health and human services and by fostering strong, sustained advances in the sciences underlying medicine, public health and social services.

Divisions shall address the Department's mission and performance objectives in carrying out the Department Tribal Consultation Policy.

Generally, one such objective promotes increasing access to health care (closing the gaps in health care). Specifically, Division performance is measured on the division's ability to increase access to quality health care services for AI/ANs, and to eliminate racial and ethnic health disparities. Another objective is to expand consumer choices in health care and human services. Other Division objectives emphasize preventive health measures, health outcomes, improve the quality of health care, and improve the well being and safety of families and individuals, especially vulnerable populations. Objectives also require Divisions to strengthen American families, including, but not limited to, increase the proportion of low-income individuals and families, including those receiving welfare and who improve their economic condition, and improving the economic and social development of distressed communities. Objectives call for Divisions to reduce regulatory burden on providers and consumers of HHS services.

In meeting HHS objectives for the Department Tribal Consultation Policy, Divisions provide a status report on the outcome of Tribal budget recommendations developed through the budget formulation process as part of the budget process defined in Section 11, HHS Budget Formulation. They shall also record, evaluate and report on the Annual Regional Tribal Consultation Sessions as described in Section 9, Consultation Process.

Divisions and Indian Tribes will also promote a cooperative atmosphere to gather, share, and collect data to demonstrate the effective use of federal resources in a manner that is consistent with the Government Performance and Results Act (GPRA) performance measures and the OMB Program Assessment Rating Tool (PART); Divisions shall consult, to the greatest extent practicable and permitted by law, with Indian Tribes before taking actions that substantially affect Indian Tribes, including regulatory practices on federal matters and unfunded mandates;

1. The impact of Division activities on Tribal trust resources shall be adequately assessed and Tribal interests considered before activities are undertaken;

2. the removal of governmental procedural impediments to work directly with Indian Tribes on activities that affect trust property or governmental rights of the Indian Tribes;

3. the Divisions will work to reduce regulatory burdens by streamlining the application process for and increase the availability of waivers to Indian Tribes; and,

4. divisions operate in a collaborative manner to accomplish the goals of Executive Order 13175 and this policy.

13. EVALUATION, RECORDING OF MEETINGS, AND REPORTING

The consultation process and activities conducted within the policy should result in a meaningful outcome for the Department and for the affected Indian Tribes. In order to effectively evaluate the results of a particular consultation activity and the Department's ability to incorporate Indian Tribes' consultation input, the Department should measure, on an annual basis, the level of satisfaction of the Indian Tribes.

1. Divisions should develop and utilize appropriate evaluation measures to assess Indian Tribes' response to Department consultation conducted during a specific period to determine if the intended purpose of the consultation was achieved and to receive recommendations to improve the consultation process. The Divisions will

maintain a record of the consultation, evaluate whether the intended results were achieved, and report back to the affected Indian tribe(s) on the status or outcome, including, but not limited to, the annual sessions conducted below.

2. At a minimum, HHS conducts one Annual Tribal Budget Consultation Session to ensure the active participation of Indian Tribes in the formulation of the HHS performance budget request as it pertains to Indian Tribes, which is usually held at the HHS Headquarters in Washington, DC in the spring. The IGA shall post a record of the annual session on the IGA website within 90 days.

3. At a minimum, HHS Regional Directors conduct an Annual Regional Tribal Consultation for Divisions to consult with Indian Tribes. These sessions shall provide an opportunity to receive the Indian Tribes priorities for budget, regulation, legislation, and other policy matters. Unless otherwise specified, the IGA Annual Consultation Report shall provide an annual reporting mechanism for this purpose and all Divisions are required to participate in this report.

4. Upon completion of consultation, the Division, and affected Indian Tribes, shall determine if there are any unresolved issues that would benefit from ongoing involvement of Indian Tribes in implementation and evaluation, including, but not limited to: assess the impact of the Division's plans, projects, programs and activities on Tribal and other available resources; removing any procedural impediments to working directly with Indian Tribes; and working collaboratively with other Federal agencies in these efforts.

5. IGA, Regional Directors and the Divisions shall ensure the annual department-wide Tribal Budget Consultation session and the Annual Regional Tribal Consultation Sessions include evaluation components for receipt of verbal and written comments from participating Indian Tribes, HHS Divisions, and other invited participants to obtain immediate feedback on the consultation session conducted.

6. With the assistance of Indian Tribes, IGA will measure the implementation and effectiveness of this Policy. IGA will assess the Department Tribal Consultation Policy at the Annual Regional Consultation Sessions and the HHS Annual Budget Consultation Session, and utilize comments from Indian Tribes and federal participants to determine whether amendment to the Policy may be required. IGA should fully consider reconvening the Tribal Consultation Policy Revision Workgroup (TCPRW) that helped to form this policy or a similar workgroup to assist IGA in making this determination.

7. The Divisions and the Regional Directors will report at each regional Tribal consultation session, what actions were taken as a result of the previous regional Tribal consultation session and describe how HHS addressed the consultation evaluation comments received by participants.

8. Divisions are required to submit to IGA the fiscal year Tribal consultation information within 90 days from the end of the fiscal year. IGA shall compile the Division submissions, and publish and distribute the information to the Indian Tribes within 60 days from receipt of the Division reports. The IGA, Regional Directors and Divisions shall also report the Department's views on the level of attendance and response from Tribal leaders during the Annual Department-Wide Tribal Budget Consultation Session and the Annual Regional Tribal Consultation Sessions, including evaluative comments, and provide advice and recommendations regarding the Tribal consultation process. The IGA shall post on the website, the IGA Annual Tribal Consultation Report, including the evaluation results at http://www.hhs.gov/ofta.

9. All national and regional consultation meetings and recommended actions shall be formally recorded and made available to Indian Tribes. Once the consultation process is complete and any policy decision is finalized, all recommended follow-up actions adopted shall be implemented and tracked by the appropriate Division and reported to the Indian Tribes in the IGA Annual Tribal Consultation Report.

14. CONFLICT RESOLUTION

The intent of this policy is to provide increased ability to solve problems. However, inherent in the government-to-government relationship, Indian Tribes may elevate an issue of importance to a higher or separate decision-making authority.

Agencies shall consult with Indian Tribes to establish a clearly defined conflict resolution process under which Indian Tribes: 1) bring forward concerns which have a substantial direct effect, and 2) apply for waivers of statutory and regulatory requirements that are subject to waiver by the Division.

Nothing in the Policy creates a right of action against the Department for failure to comply with this Policy.

15. SUPERSEDURE

Department Policy on Consultation with American Indian/Alaska Native Tribes and Indian Organizations dated August 7, 1997. Tribal Consultation Plan, U.S. Department of Health and Human Services, Office of the Secretary – Staff Divisions

16. EFFECTIVE DATE

Department Tribal Consultation Policy, U.S. Department of Health and Human Services This policy is effective on the date of the signature by the Secretary of Health and Human Services. (Signed January 14, 2005).

This policy replaces the Tribal Consultation Plan for the Office of the Secretary Staff Divisions and it applies to all Operating Divisions. Operating Divisions shall complete necessary revisions to their existing Division consultation policy/plan to conform to the revised Department Tribal Consultation Policy.

17. SUMMARY

In developing this Policy a wide range of needs across HHS, as well as the unique characteristics of the Divisions that comprise it were taken into account. As there is diversity among the Divisions, there is also a need for Divisions to be responsive to changes, which occur within their programs and within their constituency. Hence, it is important that consultation plans developed by Divisions remain dynamic, changing as circumstances and Indian Tribes input indicate. The Department should strengthen and make every effort with those of other departments and agencies. Such intra-governmental coordination will benefit the departments and agencies as well as the Indian Tribes.

18. DEFINITIONS

1. **Agency –** Any authority of the United States that is an "agency" under 44 USC 3502(1) other than those considered to be independent regulatory agencies, as defined in 44 USC 3502 (5).

2. **Communication –** The exchange of ideas, messages, or information, by speech, signals, writing, or other means.

3. **Consultation –** An enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

4. **Coordination and Collaboration –** Working and communicating together in a meaningful government-to-government effort to create a positive outcome.

5. **Critical Events –** Planned or unplanned events that have or may have a substantial impact on Indian Tribes or Native communities, e.g., issues, polices, or budgets which may come from any level within HHS.

6. **Deliberative Process Privilege –** Is a privilege exempting the government from disclosure of government agency materials containing opinions, recommendations, and other communications that are part of the decision-making process within the agency.

7. **Executive Order –** An order issued by the Government's executive on the basis of authority specifically granted to the executive branch (as by the U.S. Constitution or a Congressional Act).

8. **Federally Recognized Tribal governments –** Indian Tribes with whom the Federal Government maintains an official government-to-government relationship; usually established by a federal treaty, statute, executive order, court order, or a Federal Administrative Action. The Bureau of Indian Affairs (BIA) maintains and regularly publishes the list of federally recognized Indian Tribes.

9. **HHS Tribal Liaisons –** HHS staff designated by the head of an HHS Division that are knowledgeable about the Division's programs and budgets, and have ready access to senior program leadership, and are empowered to speak on behalf of that Division for AI/AN/NA programs, services, issues, and concerns.

10. **Indian Organization –** Any group, association, partnership, corporation, or legal entity owned or controlled by Indians, or a majority whose members are Indians.

11. **Indian Tribe –** Any Indian Tribe, band, nation or other organized group or community including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians. (25 U.S.C. Sec 450b).

12. **Indian –** Indian means a person who is a member of an Indian tribe. 25 U.S.C. 450b(d). Throughout this policy, Indian is synonymous with American Indian/Alaska Native.

13. **Intradepartmental Council on Native American Affairs (ICNAA) –** Authorized by the Native American Programs Act of 1974 (NAPA), as amended. The ICNAA serves primarily to perform functions and develop recommendations for short, intermediate, or long-term solutions to improve AI/AN/NA policies and programs as well as provide recommendations on how HHS should be organized to administer services to the AI/AN/NA population.

14. **Joint Tribal/Federal Workgroups and or/Task Forces –** A group composed of individuals who are elected Tribal officials, appointed by federally recognized Tribal governments and/or federal agencies to represent their interests while working on a particular policy, practice, issue and/or concern.

15. **Native American (NA) –** Broadly describes the people considered indigenous to North America.

16. **Native Hawaiian –** Any individual whose ancestors were natives of the area, which consists of the Hawaiian Islands prior to 1778 (42 U.S.C. 3057k).

17. **Native Organization –** A nongovernmental body organized and operated to represent the interests of a group of individuals considered indigenous to North American countries. Organizations that represent the interests of individuals do not fall under the intergovernmental committee exemption to FACA found under 2 U.S.C. Sec 1534. Therefore, the Department is required to adhere to FACA if representatives of those organizations are included on advisory committees or workgroups.

18. **Non-Recognized Tribe –** Tribe with whom the Federal Government does not maintain a government-to-government relationship, and to which the Federal Government does not recognize a trust responsibility.

19. **Policies that have Tribal Implications –** Refers to regulations, legislation, and other policy statements or actions that have substantial direct effects on one or more Indian Tribes, on the relationship between the Federal Government and Indian Tribes, or on the distribution of power and responsibilities between the Federal Government and Indian Tribes.

20. **Public Participation –** When the public is notified of a proposed or actual action, and is provided meaningful opportunities to participate in the policy development process.

21. **Reservation –** Lands reserved with the Federal Government for Tribal use and are usually held in trust by the Federal Government or within certain defined boundaries.

22. **Self Government –** Government in which the people who are most directly affected by the decisions make decisions.

23. **Sovereignty –** The ultimate source of political power from which all specific political powers are derived.

24. **State Recognized Tribes –** Tribes that maintain a special relationship with the State government and whose lands and rights are usually recognized by the State. State recognized Tribes may or may not be federally recognized.

25. **Substantial Direct Compliance Costs –** Those costs incurred directly from implementation of changes necessary to meet the requirements of a federal regulation. Because of the large variation in Tribes, "substantial costs" is also variable by Indian Tribe. Each Indian Tribe and the Secretary shall mutually determine the level of costs that represent "substantial costs" in the context of the Indian Tribe's resource base.

26. **To the Extent Practicable and Permitted by Law –** Refers to situations where the opportunity for consultation is limited because of constraints of time, budget, legal authority, etc.

27. **Treaty –** A legally binding and written agreement that affirms the government-to-government relationship between two or more nations.

28. **Tribal Government –** An American Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community that the Secretary of the Interior acknowledges to exist as an Indian Tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 USC 479a.

29. **Tribal Officials –** Elected or duly appointed officials of Indian Tribes or authorized inter-Tribal organizations.

30. **Tribal Organization –** The recognized governing body of any Indian Tribe; any legally established organization of American Indians and Alaska Natives which is controlled, sanctioned, or chartered by such governing body or which is democratically elected by the adult members of the community to be served by such organization and which includes the maximum participation of Indian Tribe members in all phases of its activities (25 U.S.C. 450b).

31. **Tribal Resolution –** A formal expression of the opinion or will of an official Tribal governing body which is adopted by vote of the Tribal governing body.

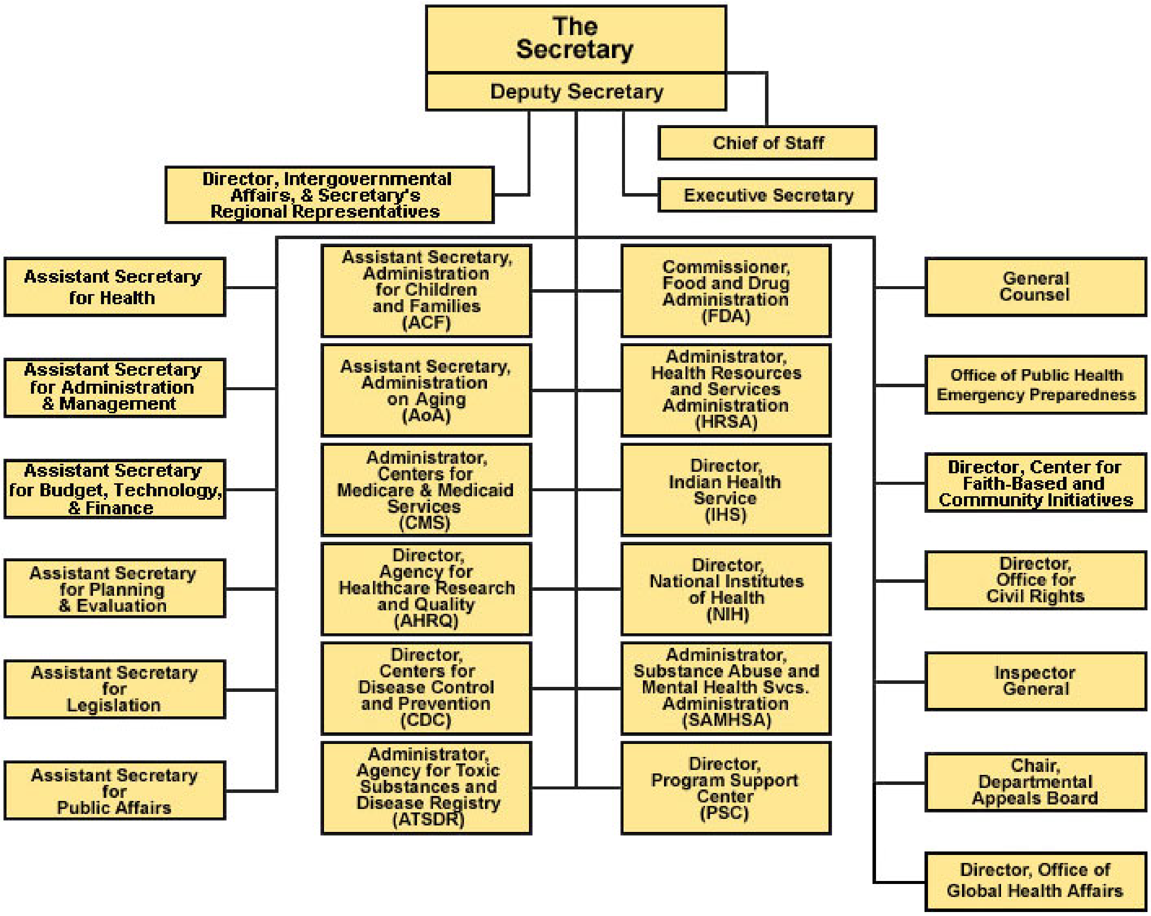
32. **Tribal Self–Governance –** The governmental actions of Tribes exercising self-government and self-determination.

33. **Urban Indian Organization –** A program that is funded by the Indian Health Service under Title V (Section 502 or 513) of the Indian Health Care Improvement Act.

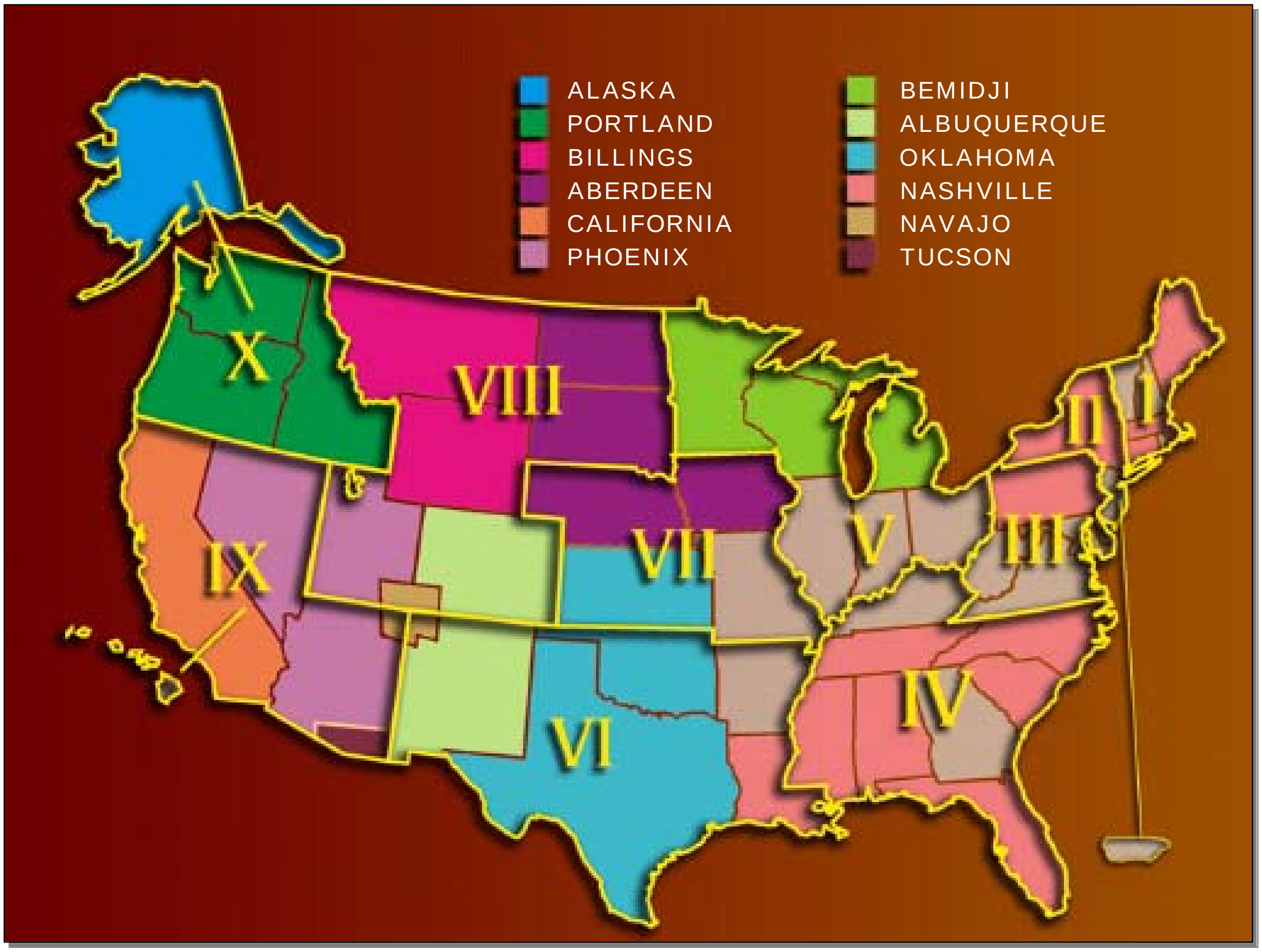
19. ACRONYMS

AI/AN:	American Indian/Alaska Native
AI/AN/NA:	American Indian/Alaska Native/Native American
ASBTF:	Assistant Secretary for Budget, Technology and Finance
BIA:	Bureau of Indian Affairs
Division:	Staff Division and/or Operating Division
EO:	Executive Order
FACA:	Federal Advisory Committee Act
FR:	*Federal Register*
GPRA:	Government Performance Results Act
HHS:	U.S. Department of Health and Human Services
ICNAA:	Intradepartmental Council on Native American Affairs
IGA:	Office of Intergovernmental Affairs
IHS	Indian Health Service
IOS:	Immediate Office of the Secretary
NPRM:	Notice of Proposed Rule Making
OMB:	Office of Management and Budget
OS:	Office of the Secretary
PART:	Performance Assessment Rating Tool
TCPRW:	Tribal Consultation Policy Revision Workgroup
U.S.:	United States
U.S.C.:	United States Code

G: HHS ORGANIZATIONAL CHART



H: INDIAN HEALTH SERVICE AREAS MAP



I: LIST OF ACRONYMS

ATNW	Affiliated Tribes of the Northwest
ACF	Administration for Children and Families
ACYF	Administration on Children, Youth and Families (ACF)
AHRQ	Agency for Healthcare Research and Quality
AI/AN	American Indian and Alaska Native
AI/AN/NA	American Indian and Alaska Native and Native American
AIHEC	American Indian Higher Education Consortium
AIP	Arctic Investigations Program
ANA	Administration for Native Americans (ACF)
ANHB	Alaska Native Health Board
AoA	Administration on Aging
APHSA	American Public Human Services Association
ASAM	Assistant Secretary for Administration and Management
ASBTF	Office of the Assistant Secretary for Budget, Technology and Finance
ASH	Assistant Secretary for Health (heads OPHS)
ASL or “L”	Office of the Assistant Secretary for Legislation
ASPA	Office of the Assistant Secretary for Public Affairs
ASPE or “P&E”	Office of the Assistant Secretary for Planning and Evaluation
ASPHEP	Office of the Assistant Secretary for Public Health Emergency Preparedness
ATSDR	Agency for Toxic Substances and Disease Registry
BHPr	Bureau of Health Professions
BIA	Bureau of Indian Affairs
BPHC	Bureau of Primary Health Care (HRSA)
CAPTs	Centers for the Application of Prevention Technologies
CB	Children’s Bureau (ACF)
CCB	Child Care Bureau (ACF)
CCDF	Child Care and Development Fund
CDC	Centers for Disease Control and Prevention
CERT	Community Emergency Response Team
CFSP	Child and Family Service Plans
CFSR	Child and Family Service Review
CHC	Community Health Center(s)
CHR	Community Health Representative

CHS	Contract Health Services
CMHS	Center for Mental Health Services
CMS	Centers for Medicare and Medicaid Services
COTPER	Coordinating Office of Terrorism Preparedness and Emergency Response
CSAP	Center for Substance Abuse Prevention
CSAT	Center for Substance Abuse Treatment
CSBG	Community Services Block Grant
CSC	Contract Support Cost
CSE	Child Support Enforcement
CVD	Cardiovascular Disease
Department	Department of Health and Human Services
DHAP	Division of HIV/AIDS Prevention (CDC)
DME	Durable Medical Equipment
DEMERC	Durable Medical Equipment Regional Carriers
DRH	Division of Reproductive Health (CDC)
DS	Deputy Secretary
DST	Direct Services Tribes
DSTDP	Division of STD Prevention
DTLL	Dear Tribal Leader Letter
EARDA	Extramural Associates Research Development Award (NIH)
ELP	Emerging Leader Program
EMS	Emergency Medical Services
EMSC	Emergency Medical Services for Children
EO	Executive Officer
EPA	Environmental Protection Agency
ES	Executive Secretary to the Department
EWIDS	Early Warning Infectious Disease Surveillance
FAAB	Facilities Appropriation Advisory Board
FACA	Federal Advisory Committee Act
FAP	Federal Advisory Panel
FAS	Fetal Alcohol Syndrome
FBCS	Faith Based and Community Services
FDA	Food and Drug Administration
FIC	Fogarty International Center (NIH)

FMAP	Federal Medical Assistance Percentage
FOH	Federal Occupational Health
FQHC	Federally Qualified Health Center
FN	First Nations
FR	Federal Register
FSS	Federal Supply Schedule
FY	Fiscal Year
FYSB	Family and Youth Services Bureau (ACF)
GPRA	Government Performance Results Act
GSGS	Good Start, Grow Smart initiative
HCUP	Health Care Utilization Project
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HIV	Human Immunodeficiency Virus
HPSA	Health Professions Shortage Area
HRSA	Health Resources and Services Administration
IAA	Interagency Agreement
ICNAA	Intradepartmental Council on Native American Affairs
ICs	Institutes and Centers at NIH
ICWA	Indian Child Welfare Act
IGA	Office of Intergovernmental Affairs
IHCIA	Indian Health Care Improvement Act
IHS	Indian Health Service
INSP	National Institute of Salud Pu’blica
IOS	Immediate Office of the Secretary
IPY	International Polar Year
ISDEAA	Indian Self Determination and Education Assistance Act
I/T/U	Indian Health Service, Tribal, and Urban Indian
LIHEAP	Low Income Home Energy Assistance Program
MAM	Medicaid Administrative Matching
MCH	Division of Maternal-Child Health
MFP	Minority Fellowship Program
MMA	Medicare Modernization Act, a.k.a. Prescription Drug Plan, Medicare Part D
NARCH	Native American Research Centers for Health

NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NCAI	National Congress of American Indians
NCCCP	National Comprehensive Cancer Control Program
NCHSTP	National Center for HIV, STD, and TB Prevention
NCSD	National Coalition of STD Directors
NCVHS	National Committee on Vital and Health Statistics
NDEP	National Diabetes Education Program
NDWP	National Diabetes Wellness Program
NEW	Native Employment Works
NGO	Non-Governmental Organization
NHAP	National HIV/AIDS Partnership
NHDR	National Healthcare Disparities Report
NHIS	National Health Interview Survey
NHQR	National Healthcare Quality Report
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NICCA	National Indian Child Care Association
NICOA	National Indian Council on Aging
NICWA	National Indian Child Welfare Association
NIH	National Institutes of Health
NIHB	National Indian Health Board
NIMH	National Institute of Mental Health
NIP	National Immunization Program
NPAIHB	Northwest Portland Area Indian Health Board
NPRM	Notice of Proposed Rule Making
NUI	Nevada Urban Indians, Inc.
OA	Office of the Administrator
OCR	Office for Civil Rights
OCS	Office of Community Services
OCSE	Office of Child Support Enforcement
OFA	Office of Family Assistance
OFRD	Office of Force Readiness and Deployment
OGC or "GC"	Office of General Counsel
OMB	Office of Management and Budget

OMH	Office of Minority Health
OPHS	Office of Public Health and Science
ORD	Office of the Regional Director
ORHA	Office of the Regional Health Administrator
OS	Office of the Secretary
PART	Program Effectiveness Rating Tool
PMF	Presidential Management Fellow
PSA	Public Service Announcement
RH	Reproductive Health
RMHC	Regional Minority Health Coordinator
RPMS	Resource and Patient Management System
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Severe Emotional Disturbance
SERG	SAMHSA Emergency Response Grant
SHIP	State Health Insurance Program
SSA	Social Security Administration
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Diseases
TA	Technical Assistance
TANF	Temporary Assistance to Needy Families
TCE	Targeted Capacity Expansion Program
TCP	Tribal Consultation Policy
TCPRW	Tribal Consultation Policy Revision Workgroup
TCU	Tribal Colleges and Universities
TEHEP	Tribal Environmental Health Education Program
TriTac	Tribal Child Care Technical Assistance Center
TLDC	Tribal Leaders Diabetes Committee
TSGAC	Tribal Self-Governance Advisory Committee
TTAG	Tribal Technical Advisory Group (CMS)
USDA	U.S. Department of Agriculture
USET	United South and Eastern Tribes, Inc.
VA	Veterans Administration
VFC	Vaccine for Children
WINS	Washington Internships for Native Students